

**Unconventional Therapies in General Practice: Boundary Construction, Identity  
and Authentication**

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**Ph.D. Thesis**

**University of Edinburgh**

**2000**



## **Abstract**

The field of unconventional medicines - including acupuncture, homeopathy and hypnotherapy - has undergone far-reaching developments over the last twenty years. A significant number of patients are now using unconventional medicines, the ranks of non-medically qualified therapists have swollen dramatically and the therapies have become a central topic of public and professional debate.

Alongside this general expansion there has been a growing interest in other medicines from within the orthodox medical community. While unconventional therapies are still located predominantly outside both National Health Service (NHS) provision and the practice of the medical profession, a range of health care professionals have attempted to forge closer working relations with unconventional medicines. General practice has become a particularly important site for integration and a small yet growing number of general practitioners (GPs) are personally practising one or a range of unconventional techniques in addition to more conventional medicines to treat their NHS patients.

This thesis constitutes the first detailed exploration of rank and file GPs' accounts of their direct integrative practice. Based on transcripts from twenty-five in-depth interviews conducted with GPs practising unconventional therapies in Edinburgh and Glasgow, the thesis critically examines their descriptions and presentations of their unconventional practice. Particular emphasis is placed on examining the rhetorics and boundary-work conducted in the accounts as the doctors attempt to appropriate and authenticate the therapies in the general practice setting.

Combining social worlds theory with a number of other sociological perspectives the GPs' presentations are contextualised within wider debates and conflicts in the medical arena. While supporting earlier work which has interpreted the growing practice of unconventional medicines by doctors as an attempt to quash the threat posed by non-medically qualified therapists to medical dominance, this thesis also explores themes neglected by earlier research. Emphasis is placed upon the more positive gains unconventional practice may bring GPs involved in direct integration. The analysis demonstrates how unconventional medicines provide these doctors with a valuable resource for maintaining and enhancing their professional identity and territory with regard to both current inter-professional and intra-professional struggles.



15<sup>th</sup> September 2000

I declare that this thesis is my own work throughout.

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## **Acknowledgments**

Many thanks to my supervisor Steve Sturdy. Without his guidance and patience I would not have started or completed this thesis.

Special mention must go to Elaine Thomson. Our long chats sat on the famous B.B. chairs (nice feature) drinking coffee have been a great source of encouragement. I only wish this thesis could provide the answer to one crucial question. How much does Mr E. House make on a muffin?

Thanks to Carole Tansley for helping make my time at the Science Studies Unit a happy one, especially on those cold wet winter mornings.

I must also thank all my family for their love and support over the last four years. Special thanks to my grandma, Sallie Beeby, for her wit and chat. Other people who have provided valuable help and encouragement are: Abbi Wills; Phil Tovey; Steve Kemp; Tom McGlew; Mike Porter; Ki-Heung Kim; Yuval Millo; and Helen Coyle. I also thank Anne Kerr and Tina Thiel for their time reading and making valuable comments on earlier drafts of the thesis.

Finally, I would like to thank all the general practitioners who participated in the study. I have enjoyed listening to their descriptions and medical tales and I am grateful to them for allowing me so much of their valuable time.

As far as my freedom goes...the group of which I am a member plays an ambivalent role. On one hand it enables me to be free; on the other it constrains me by drawing the borders of my freedom. It enables me to be free as it imparts the sort of desires which are both acceptable and 'realistic' inside my group, teaches me to select the ways of acting which are appropriate to the pursuit of such desires, and gives me the ability to read the situation properly and hence to orientate myself correctly to the actions and intentions of others who influence the outcome of my efforts. At the same time it fixes the territory within which my freedom may be properly exercised, as all the many assets I owe to it, all the invaluable skills I acquired from my group turn from advantages into liabilities the moment I venture beyond the boundary of my own group and find myself in an environment where different desires are promoted, different tactics are deemed appropriate, and the connections between other people's conduct and their intentions are not like those I have come to expect.

Bauman, Z. (1990). *Thinking Sociologically*. Oxford, Blackwell. pp.23-24.

I think complementary medicine and conventional medicine have to be linked together. I think its almost like, I don't think, even think you could call it two intersecting circles. I think it has to be all in one big circle. I think each has their own role and I would be the first to admit that I think conventional medicine does have limitations.

GP Acupuncturist interviewed in study.

## **Chapter One**

### **Context and Literature Review**



## 1.1 Introduction

This opening chapter provides a back-cloth to the rest of the thesis. I situate unconventional therapies<sup>1</sup> within contemporary British society and explore a number of key developments relating to these medicines which have occurred over the last two decades. In addition to outlining more general trends in this area, the chapter also examines an increasing interest in these therapies from within the medical profession.

I briefly discuss some of the circumstances which signal the slow yet dramatic change in the stance of the medical elite towards unconventional therapies, then I consider the changing stance of the grass-roots of the profession. Focusing specifically upon general practice I outline a number of ways integration is presently accomplished. I place particular emphasis upon exploring the rise of what is here labelled direct integrative practice - the personal practice of unconventional therapies by general practitioners alongside their more conventional medical interventions. Various studies, which have been almost exclusively small-scale, have investigated the level of interest in and practice of unconventional medicines among general practitioners (GPs) and I summarise the main findings of this research.

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<sup>1</sup> Throughout this thesis the labels 'unconventional medicines' and 'unconventional therapies' are used to denote those therapies which are still predominantly located and practised outside the boundaries of the medical profession. Exception to this rule is made where quotations from the interviews are analysed. In these cases the labels employed by the informants are used. The difficulties of employing different labels have been discussed elsewhere. For example see Sharma, U. (1992). *Complementary Medicine Today: Practitioners and Patients*. London, Routledge and Eagle, R. (1980). *A Guide to Alternative Medicine*. London, British Broadcasting Corporation. A whole range of different labels have been used to classify the therapies - 'alternative', 'complementary', 'holistic', 'traditional' amongst others - and there has been much discussion of the relative merits of the different nomenclature. However I do not wish to be drawn into such debate here due to time and space. Furthermore, as will become apparent a little later in the thesis, the use of different labels is actually a part of the phenomena being studied here; different medical groups employ different labels to describe and explain the therapies and they do so for their own ideological reasons.

A related theme which has also stirred much debate concerns which therapies are included under the various labels. This debate has been particularly wide-ranging given the possible number of therapies which may comprise this sector of medical practice. See BMA (1993). *Complementary Medicine: New Approaches to Good Practice*. Oxford, Oxford University Press. p.5. In this text 160 therapies are quoted from another source. Again I decline to contribute to these debates of inclusion/exclusion, and chapter three explains the stance of this thesis on this matter in more detail.

Questionnaire-based studies of GP involvement with unconventional medicines have been largely conducted by medics themselves and both the general integration of the different medicines and the more specific topic of direct integrative practice remain heavily under-researched by social scientists. The only direct empirical sociological research that has investigated matters of integration within the British context is the recent work of Saks and this chapter provides a brief review of his analysis.

I suggest that Saks's work is insightful in approaching and understanding issues of integration and I have no direct quarrels with his analysis. However, given the absence of empirical sociological study on matters of integration, much terrain remains unexplored, and I highlight some implicit features of Saks's approach which potentially hinder the investigation of certain research issues within the field. In particular, I argue that Saks's perspective implies a monolithic view of the medical profession and consequently fails to take account of intra-professional rivalries and debates within the medical community. Moreover, I claim that his analysis also tends to favour an investigation of the pronouncements and publications of the medical elite at the expense of any serious exploration of the attitudes and perceptions of grass-roots doctors towards unconventional therapies. The thematic approach adopted in this thesis represents a response to these concerns; a point which is illustrated in the brief overview of the remaining chapters of the thesis which concludes this chapter.

## 1.2 The Rise of Unconventional Medicines

Unconventional medicines presently occupy a subordinate role and position within the British health care system.<sup>2</sup> The therapies are still predominantly located outside the NHS and beyond the clinical interest of a significant proportion of the medical profession.<sup>3</sup> Such therapies also remain excluded from the medical curriculum currently taught in British medical schools,<sup>4</sup> and fail to attract substantial funding in terms of medical research.<sup>5</sup>

Despite these circumstances, more recent years have seen a number of developments which seem to signify a change in fortune for these therapies. There has been extensive growth in unconventional therapies over the last two decades.<sup>6</sup> This has been an international phenomenon, spreading not only across Britain and Europe, but also further afield.<sup>7</sup> Ever more patients are turning to therapists of these medicines

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<sup>2</sup> The historical development of unconventional therapies and the past relations between these therapies and the medical profession are areas of study which have attracted plenty of interest and as such they are not explored in this thesis. For a history of unconventional/conventional medical relations see Bynum, W. F. and Porter, R. (eds.) (1987). *Medical Fringe and Medical Orthodoxy*. London, Croom Helm. Cooter, R. (1988). *Studies in the History of Alternative Medicine*. London, Macmillan. For a good history of homeopathic medicine and its relations to the medical profession see Nicholls, P. A. (1988). *Homoeopathy and the Medical Profession*, London, Croom Helm. More recently other writers have also contributed to historical analysis. See Saks, M. (ed.) (1992). *Alternative Medicine in Britain*. London, Clarendon. And for a history of acupuncture in Britain see Saks, M. (1995). *Professions and the Public Interest*. London, Routledge.

<sup>3</sup> The small pockets of interest in unconventional therapies within the NHS and the medical community must be noted. For example a number of homeopathic hospitals have been part of the NHS since its origins in 1948. See Swayne, J. (1989). 'Survey of the Use of Homeopathic Medicine in the UK Health System'. *Journal of the Royal College of General Practitioners* 39: 503-506. These hospitals are particularly significant since they constitute the only unconventional medicine hospitals in Europe dedicated to public provision. See Fisher, P. and Ward, A. (1994). 'Complementary Medicine in Europe'. *British Medical Journal* 309: 107-111.

<sup>4</sup> Stephens, W. (1989). 'Consultant Attitudes to Acupuncture in a District General Hospital'. *Acupuncture in Medicine* 6(1): 20-23. Rampes, H. Sharples, F. Maragh, S. and Fisher, P. (1997). 'Introducing Complementary Medicine into the Medical Curriculum'. *Journal of the Royal Society of Medicine* 90: 19-22.

<sup>5</sup> Smith, I. (1996). 'More than Pin Money'. *Health Service Journal* 106: 24-25. p.24.

<sup>6</sup> This has been traced to growth at the turn of the 1980s in Britain. For example Inglis, B. (1980). *Natural Medicine*. London, Fontana/Collins.

<sup>7</sup> News (anon.) (1996). 'Complementary Medicine is Booming World-wide'. *British Medical Journal* 313: 131-133. For a review of the circumstances of growth in the United States see Eisenberg, D. M., Kessler, R. C., Foster, C., Norlock, F. E., Calkins, D. R., and Delbanco, T. L. (1993). 'Unconventional

for relief from medical problems<sup>8</sup> and in response the ranks of unconventional therapists in Britain have swollen dramatically.<sup>9</sup> While there is still much scope for further investigation,<sup>10</sup> numerous studies have explored the lay sector of unconventional therapies<sup>11</sup> and in the last few years researchers have begun to explore the concrete work activity of unconventional therapists and the ways in which their knowledge is transformed and maintained in local practice settings.<sup>12</sup>

This rising number of lay practitioners has prompted formal representative bodies to create tighter organisational standards within certain therapies. Indeed, some

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Medicine in the United States: Prevalence, Costs, and Patterns of Use'. *New England Journal of Medicine* 328(4): 246-252. For details of growth in other European countries see: Christie, V. M. (1991). 'A Dialogue between Practitioners of Alternative (Traditional) Medicine and Modern (Western) Medicine in Norway'. *Social Science and Medicine* 32(5): 549-552. Gevitz, N. (1993). 'Unorthodox Medical Theories'. In W. F. Bynum and R. Porter (eds). *Companion Encyclopaedia of the History of Medicine*. London, Routledge. Lewith, G. and Aldridge, D. (eds.) (1991). *Complementary Medicine and the European Community*. Saffron Walden, C. W. Daniel.

<sup>8</sup> For example one study revealed that 27% of a sample of the general public had used some form of unconventional therapy at some point in their lives: see MORI (Market and Opinion Research International) (1989). *Alternative Medicine*. Research conducted for the Times newspaper.

<sup>9</sup> For estimated figures of such growth in the number of therapists see Harvey, D. (ed.) (1986). *Thorson's Complete Guide to Alternative Living*. Wellingborough, Thorsons. Fulder, S. J. and Monro, R. (1982). *The Status of Complementary Medicine in the United Kingdom*. London, Threshold Foundation. Fulder, S. J. (1988). *The Handbook of Complementary Medicine*. Oxford, Oxford University Press. Fulder, S. J. (1992). 'Alternative Therapists in Britain'. In Saks, M. (ed.). *Op. Cit. No. 2*.

<sup>10</sup> As Cant and Sharma write, 'the novel factor in the post-1970s situation was not the existence of diverse healing modes in itself but the enormous boost in their popularity among consumers, a question that still needs to be explored more thoroughly'. Cant, S. and Sharma, U. (eds.) (1996). *Complementary and Alternative Medicines*. London, Free Association Books. pp.20-21.

<sup>11</sup> Cant, S. and Calnan, M. (1991). 'On the Margins of the Medical Marketplace? An Exploratory Study of Alternative Practitioners' Perceptions'. *Sociology of Health and Illness* 13(1): 39-57. Sharma, U. (1996). 'Situating Homeopathic Knowledge: Legitimation and the Cultural Landscape'. In S. Cant and U. Sharma (eds). *Op. Cit. No. 10*. Tovey, P. (1997). 'Contingent Legitimacy'. *Social Science and Medicine* 45(7): 1129-1133. Cant, S. (1996) 'From Charismatic Teaching to Professional Training: The Legitimation of Knowledge and the Creation of Trust in Homeopathy and Chiropractic'. In S. Cant and U. Sharma (eds). *Op. Cit. No. 10*.

<sup>12</sup> Power, R. (1996). 'Considering Archival Research in One's Own Practice'. In S. Cant and U. Sharma (eds). *Op. Cit. No. 10*. Johannessen, H. (1996). 'Individualized Knowledge: Reflexologists, Biopaths and Kinesiologists in Denmark'. In S. Cant and U. Sharma (eds.) *Op. Cit. No. 10*. This development has followed the trend within the sociology of knowledge more generally towards examining concrete work activities in local settings. As Cant and Sharma explain, 'recent studies in the sociology and anthropology of knowledge have tended to emphasise the linkages between what sociologists used to call the micro and macro levels of analysis. But the more general theorizing work has tended to privilege the macro, concentrating on achieving some kind of general characterization of the kind of society that is emerging, and how it is different from that which has gone before. These are valid questions, but in answering them the insights derived from studies of specific occupational groups and their workplaces, of the ways in which their knowledge is communicated among themselves and others...sometimes seem to get lost', Cant, S. and Sharma, U. (eds.) (1996). *Op. Cit. No. 10*. p.20.

social scientists have concentrated their efforts upon charting the professionalisation of unconventional medicines, highlighting the increasing commitment to disciplinary procedures, registration, training and qualifications within therapeutic ranks.<sup>13</sup>

Unconventional medicines have also become the focus of considerable media and public attention,<sup>14</sup> and there have been calls from a number of sources (including medical and consumer groups) for the widespread inclusion of these therapies within the NHS.<sup>15</sup> Furthermore, research suggests NHS purchasing bodies are increasingly looking to unconventional treatments as another viable health care option to offer their patient populations.<sup>16</sup> The integration of unconventional medicines in the NHS has been aided by the establishment of university departments of complementary medicine

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<sup>13</sup> Baer, H. (1984). 'The Drive for Professionalism in British Osteopathy'. *Social Science and Medicine* 19(7): 717-725. Cant, S. and Sharma, U. (1995). *Professionalisation in Complementary Medicine*. ESRC Research Report. Keele, ESRC. Sharma, U. (1992). *Op. Cit. No. 1*. Sharma, U. (1996). *Op. Cit. No. 11*. Cant, S. and Sharma, U. (1994b). 'Social Aspects of Complementary Medicine'. *Medical Sociology News* 19(3): 25-7. This process of professionalization has been particularly evident in the case of osteopathy resulting in the Osteopathy Bill being passed through parliament in 1993. Osteopathy Bill (1993). London, HMSO.

<sup>14</sup> For example see Cooper, G. (1997). 'Patients Want Touchy-Feely Treatments'. *Independent on Sunday* 30th Nov. p.12.

<sup>15</sup> Thomas, R. (1989). 'Give Us More Alternatives on the NHS'. *Journal of Alternative and Complementary Medicine* 4: 11. Burch, C. (1993). 'Alternatives on the NHS'. *Which? Way to Health* August: 125-127. Saks, a sociologist, has supported such demands. Writing about the approach of the medical profession to unconventional medicines Saks employs the notion of public responsibility to reinforce such calls: 'it seems that the restrictions that the British medical profession as a collectivity has largely imposed on both the structural location and form of alternative practice, in the face of escalating consumer demand may at least be challenged in terms of the definition of public responsibility employed here - especially as regards the more established alternative therapies, such as acupuncture and homeopathy'. Saks, M. (1994). 'The Alternatives to Medicine'. In J. Gabe, D. Keheller, and G. Williams (eds). *Challenging Medicine*. London, Routledge. p.97.

<sup>16</sup> Adams, J. (1995). 'With Compliments'. *Health Service Journal* 105(5455): p.23. Cameron-Blackie, G. (1993). *Complementary Therapies on the NHS*. Research Paper No.10. Birmingham, National Association of Health Authorities and Trusts. Whelan, J. (1995). 'Complementary Therapies and the Changing NHS: A Development Officer's View'. *Complementary Therapies in Medicine* 3: 79-83. Wilson, B. J., Goodwin, N., Grimshaw, J. M., Blumer, H., Durno, D., Wilson, H., et al. (1996). 'Complementary Therapies in a Local Healthcare Setting'. *Complementary Therapies in Medicine* 4: 118-123. Also on an international level the World Health Organisation (WHO) has encouraged co-operation and mutual respect between the practitioners of different medicines, and has highlighted the potential role of unconventional medicines in both national and international health purchasing and co-ordination strategies: see World Health Organisation (1978). 'The Promotion and Development of Traditional Medicine'. In *Report of a WHO Meeting*. Technical Report Series, 622. Geneva, World Health Organisation. Bannerman, R. H., Burton, J., and Ch'en Wen-Chieh (1983). *Traditional Medicine and Health Care Coverage*. Geneva, World Health Organisation.



which encourage systematic research and debate about a number of therapies,<sup>17</sup> and medical research evaluating different techniques and treatments has begun to emerge.<sup>18</sup>

Much effort has been spent by social scientists in explaining the ascendancy of unconventional therapies. While some have proposed that the trend is part of a new age cultural movement,<sup>19</sup> most have been more conservative in their analyses, pointing to a growing demand from patients for a more personal medical relationship and an increasing public awareness of the iatrogenic effects of conventional medicine.<sup>20</sup> While these debates rotate around what still remain interesting sociological themes I do not intend to address them directly here. Instead, I want to focus upon the role of the medical profession in relation to unconventional therapies, a role which has been largely overlooked by social scientists. In line with this aim I now examine the changing relationship between unconventional medicines and the medical community.

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<sup>17</sup> There are departments at the University of Southampton and the University of Exeter for example.

<sup>18</sup> For example see Kleijnen, J., Knipschild, P. and ter Riet, G. (1991). 'Clinical Trials of Homeopathy'. *British Medical Journal* 302: 316-323 and Reilly, D. T., Taylor, M. A., McSharry, C. and Aitchison, T. (1986). 'Is Homoeopathy a Placebo Response? Controlled Trial of Homoeopathic Potency, with Pollen in Hay Fever as Model'. *Lancet* 333(2): 881-885.

<sup>19</sup> Coward, R. (1989). *The Whole Truth: The Myth of Alternative Health*. London, Faber and Faber.

### 1.3 Growth in Medical Interest

Alongside the more general expansion of unconventional medicines has been an increasing interest in these therapies from within the medical community.<sup>21</sup> Examining the stance of a number of formal representative bodies from within the profession I chart some important milestones in the general movement towards a closer relationship between the two medicines. In order to analyse these changes I begin my account with a discussion of the 1986 British Medical Association (BMA) report on alternative therapy, a document which speaks discouragingly of and is unsympathetic to unconventional medicines.

In the mid-1980s the BMA set up a working party to study unconventional therapies. The party present their aim as being 'to consider the feasibility and possible methods of assessing the value of alternative therapies, whether used alone or to complement other treatments',<sup>22</sup> and their conclusions are presented in the BMA report of 1986.<sup>23</sup> The result of the working party's efforts is a fierce and scathing criticism of unconventional medicine. As a means of distancing from and attempting to discredit unconventional medicines the report refers to the 'scientific method'. To quote the BMA:

there is one fundamental and consistent strand to the argument which creates a division consistently separating medical orthodoxy from alternative

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<sup>20</sup> Fulder, S. J. (1988). *Op. Cit. No. 9*. Bakx, K. (1991). 'The "Eclipse" of Folk Medicine in Western Society'. *Sociology of Health and Illness* 13(1): 20-23. Sharma, U. (1992). *Op. Cit. No. 1*.

<sup>21</sup> West, R. and Inglis, B. (1985). 'Taking the Alternative Road to Health'. *The Times* 13 March. Thomas, K. (1990). 'Non-Orthodox Healthcare in the UK'. *Complementary Medical Research* 4(2): 32-34. Doctors have never been formally prohibited from unconventional practice within the NHS. Likewise practice by unconventional therapists has not been restricted either (apart from treating a few illnesses such as cancer) as long as they do not claim to be registered doctors. Sharma, U. (1992). *Op. Cit. No. 1*. p.96. Huggon, T. and Trench, H. (1992). 'Brussels Post-1992: Protector or Prosecutor?'. In Saks, M. (ed.). *Op. Cit. No. 2*.

<sup>22</sup> BMA (1986). *Alternative Therapy: Report of the Board of Science and Education*. London, BMA. p.211.

<sup>23</sup> BMA (1986). *Ibid.*

approaches. This is that the work and approach of the medical profession are based on scientific method, defining 'science' in the strictest sense of the word, namely the systematic observation of natural phenomena for the purpose of discovering laws governing those phenomena.<sup>24</sup>

In contrast to the scientific approach of the medical orthodoxy, unconventional therapies are cast by the report as 'doctrines embracing superstition, magic, and the supernatural'<sup>25</sup> and are rejected on the grounds of their 'non-scientific' knowledge base.

What is most obvious about the 1986 report is that it concentrates upon praising and defending conventional medicine<sup>26</sup> at the expense of undertaking any in-depth exploration of the unconventional treatments available - an approach which seems deficient given the overall stated aims of the investigation. In particular, the working party is preoccupied with explaining the recent popularity of unconventional medicines as a result of unrealistic expectations on the part of patients, a situation brought about, so the report suggests, by the very success and advances of conventional medicine.

Despite this preoccupation, the report does include a brief review of selected unconventional therapies and their relevance to medical practice. Nevertheless, while some therapies (e.g. manipulation) are seen as holding some scientific validity the majority are dismissed as offering no more benefit than a placebo.

What is interesting about the 1986 report is how it differs in its approach from a range of other official pronouncements on unconventional therapies presented elsewhere by the BMA and other elite medical bodies. The 1986 report did not escape

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<sup>24</sup> BMA (1992). 'Report on Alternative Medicine'. In Saks, M. (ed.). *Op. Cit. No. 2*. pp.211-212.

<sup>25</sup> BMA (1992). *Ibid.* p.212.

<sup>26</sup> For example the BMA suggest, 'the fact is that the steadily developing body of orthodox medical knowledge has led to large, demonstrable, and reproducible benefits for mankind, of a scale which cannot be matched by alternative approaches', BMA (1992). *Ibid.* p.213.



criticism, even from within the medical profession itself.<sup>27</sup> Numerous letters appeared in medical journals from practitioners attacking the report's approach and the British Holistic Medical Association (BHMA) - a body of general practitioners created in 1983 to promote holistic practice within the medical profession - produced its own counter-report which condemned some of the main points made by the working party.<sup>28</sup> Furthermore, the stance towards unconventional medicines which lay behind such criticism of the BMA report was not new. Earlier, members of the Royal College of General Practitioners had promoted support for the use of selected therapies by general practitioners<sup>29</sup> and the BHMA has, since its foundation, cautiously encouraged the incorporation of unconventional therapies alongside more conventional treatments.<sup>30</sup> Debate relating to unconventional treatments has become more prominent within medical journals<sup>31</sup> and it seems likely that the increasing pressures from members of the profession have been at least partly significant in influencing the decision of the BMA to commission a second report published in 1993.

The change in position between this and the earlier report is strikingly reflected in a differing use of titles to describe the therapies, with a shift from 'alternative' in 1986 to 'complementary' in 1993. In contrast to the claims of the

<sup>27</sup> See Fairfoot, P. (1987). 'Alternative Therapies: The BMA Knows Best?'. *Journal of Social Policy* 16(3): 383-390.

<sup>28</sup> BHMA (1986). *BHMA Response to the BMA's Report: Alternative Therapy*. London, BHMA.

<sup>29</sup> Pinsent, R. J. F. K. (1980). 'Why Not Consider Homeopathy?'. *Journal of the Royal College of General Practitioners* 30: 372. Fletcher, T. S. (1983). 'The Need to Study Complementary Medicine'. *Journal of the Royal College of General Practitioners* 42 (7): 677-678.

<sup>30</sup> While the BHMA suggests it 'is committed to supporting the NHS and encouraging the introduction of the complementary therapies within it' (Pietroni, P. C. (1986). 'Holism, Complementary Therapy and Primary Care'. *Holistic Medicine* 1: 91.) - an integration which is envisaged as inviting complementary practitioners into the primary care setting - the association has also been quick to clarify that it is not specifically a formal body promoting just unconventional therapies but instead one that advocates broader holistic aims in primary care.

<sup>31</sup> For details see Saks, M. (1991). 'The Flight From Science? The Reporting of Acupuncture in Mainstream British Medical Journals from 1800 to 1990'. *Complementary Medical Research* 5(3): 178-181. Also for discussion of earlier journal coverage of acupuncture see Webster, A. J. (1979). 'Scientific Controversy and Socio-Cognitive Metonymy: The Case of Acupuncture'. In R. Wallis (ed.). *On the Margins of Science*. Sociological Review Monograph, no. 27. Keele, University of Keele.

working party in 1986, this more recent report devotes much effort to outlining and appraising various unconventional therapies. In most cases the report suggests that some benefits can be obtained from restricted practice alongside conventional techniques, and some guidelines for good unconventional practice are outlined.<sup>32</sup> While the report still falls short of a wholesale promotion of unconventional medicine it does, nevertheless, reflect a serious change in tack for the BMA.

Moving away from the official statements of the medical elite and turning attention to the grass-roots of the profession we can identify additional, arguably more significant, developments relating to the integration of unconventional therapies. Interest in and practice of unconventional medicines is apparent across many different sectors of the medical community;<sup>33</sup> research has revealed the use of aromatherapy, reflexology and massage within nursing,<sup>34</sup> and acupuncture has attracted interest within certain hospital specialisms.<sup>35</sup>

More significantly for our purposes, general practice has not been exempt from these developments, and evidence would appear to support the view that it is primarily

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<sup>32</sup> These guidelines include recommendations concerning registration, professional standards and training and qualifications amongst unconventional practitioners.

<sup>33</sup> It must be noted that such practice and interest would appear to be somewhat selective with certain therapies (e.g. acupuncture, homeopathy and osteopathy) receiving relatively more support than others (e.g. crystal healing and Kirlian photography). Trevelyn describes these latter therapies as 'new fringe' suggesting they find themselves 'in the same position as the more established therapies were some twenty years ago', Trevelyn, J. (1995). 'The New Fringe?'. *Nursing Times* 91(11): 26-28, p.26. Also see Tovey, P. (1997). *Op. Cit. No. 11*.

<sup>34</sup> Armstrong, F. (1991). 'A Complementary Strategy'. *Nursing Times* 87(11): 34-35. Editorial (1990). 'Complementary Therapies in Nursing Practice'. *Nursing Times* 86(4): 25. Trevelyn, J. (1995). *Op. Cit. No. 33*. Rankin-Box, D. (ed.) (1988). *Complementary Health Therapies: A Guide for Nurses and the Caring Professions*. London, Croom Helm.

<sup>35</sup> Camp, V. (1986). 'Acupuncture in the NHS'. *Acupuncture in Medicine* 3(1): 4-5. Dale, J. (1996). 'Practising Acupuncture Today: A Postal Questionnaire of Medical Practitioners'. *Acupuncture in Medicine* 14(2): 104-108. Lewith, G. T. (1985). 'Acupuncture and Transcutaneous Nerve Stimulation'. In Lewith, G. T. (ed.) *Alternative Therapies: A Guide to Complementary Medicine for the Health Professional*. London, Heinemann.

in this branch of medicine 'that these therapies are making their presence felt'.<sup>36</sup> Indeed, we can distinguish three broad models of integration of unconventional therapies within general practice. One model has been through the extension of the multidisciplinary primary care team, where unconventional therapists have been invited into the primary care setting to work alongside GPs and other health care professionals.<sup>37</sup> There are two main variants of this model of integration. While some projects have encouraged non-medically qualified therapists to take an active and equal role in treatment decisions,<sup>38</sup> the majority have allocated a subordinate location and role for the therapist with the GP maintaining overall clinical responsibility for the patient.<sup>39</sup> To date, these multidisciplinary initiatives remain localised and relatively few in number.

Another more popular form of integration has developed around referral networks. Numerous studies have shown that some GPs are referring patients for complementary therapies.<sup>40</sup> While these referrals are still at the discretion of the

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<sup>36</sup> Peters, D. (1994) 'Sharing Responsibility for Patient Care'. In S. Budd and U. Sharma (eds). *The Healing Bond: The Patient-Practitioner Relationship and Therapeutic Responsibility*. London, Routledge. p.171. Saks also supports this analysis, see Saks, M. (1994). *Op. Cit. No. 15*. p.88.

<sup>37</sup> Pietroni, a doctor who has commented extensively on unconventional medicines and who has also participated in the Marlyebone Health centre initiative, explains how he sees such teams: 'my view is that although our roots may lie in medical schools and our current identity is that of general practice, our future lies as members and, at times, leaders of an expanded primary health and community care team, which among others, must include selected complementary practitioners'. Pietroni, P. C. (1992). 'Beyond the Boundaries: The Relationship Between General Practice and Complementary Medicine'. *British Medical Journal* 305: 564-566.

<sup>38</sup> Paterson, C. and Peacock, W. (1995). 'Complementary Practitioners as Part of the Primary Health Care Team: Evaluation of One Model'. *British Journal of General Practice* 45: 255-258. One particular yet until now unique project set up in 1987, the Hoxton Health Centre, is completely run by lay therapists as part of the NHS. See Cooper, G. (1997). *Complementary medicine on the NHS*. <http://www.newciv.org/worldtrans/bov/bov/bv-227.html>.

<sup>39</sup> Budd, C., Fischer, B., Parrinder, D., Price, L. (1990). 'A Model of Co-operation Between Complementary and Allopathic Medicine in a Primary Care Setting'. *British Journal of General Practice* 40: 376-378. Pietroni, P. C. (1992). *Op. Cit. No. 37*. Pietroni, P. C. and Chase, H. D. (1993). 'Partners or Partisans? Patient Participation at Marlyebone Health Centre'. *British Journal of General Practice* 43: 341-344. Reason, P. *et al.* (1992). 'Towards a Clinical Framework for Collaboration between General Practice and Complementary Practitioners: Discussion Paper'. *Journal of the Royal Society of Medicine* 85: 161-164.

<sup>40</sup> Prior to the 1980s there was little enthusiasm and support from general practitioners to encourage referrals for unconventional therapies. See Consumers Association (1972). 'Acupuncture'. *Which?*

individual GP they have been greatly encouraged by the General Medical Council relaxing its ruling on this area of practice in the mid-1970s.<sup>41</sup> This model of integration can take the form of either direct referral or encouraging the patient to self-refer and can be to either a medically-qualified colleague or to a lay therapist.

A third and arguably more controversial model of integration between general practice and unconventional therapies is *direct integrative practice*. This is where the GP personally practises one or more unconventional therapy alongside more conventional medical methods to treat NHS patients. As the next section explains, there is evidence that the number of such GPs has been growing in the last twenty years.

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February: 49-51. Also for discussion of referrals and attempts to refine the GP referral system to include unconventional therapists, see Murray, J. and Sheperd, S. (1988). 'Alternative or Additional Medicine? A New Dilemma for the Doctor'. *Journal of the Royal College of General Practitioners* 38: 511-514. Peters, D., Davies, P. and Pietroni, P. C. (1994). *Introducing Osteopathy to General Practice: An Audit Cycle*. London, North West Thames AHA.

## 1.4 General Practitioners and Direct Integrative Practice

A body of work authored almost exclusively by medical practitioners has developed over the last two decades examining their profession's attitudes and behaviours relating to complementary therapies.<sup>42</sup> These studies provide a preliminary exploration of a range of issues relating to general practice and the integration of unconventional therapies. However, my concern here is to highlight findings from these studies which relate more particularly to direct integrative practice - a form of integration which, as will be seen shortly in the thesis, raises a number of interesting sociological questions.

The first study of this kind was conducted by Reilly in the early 1980s.<sup>43</sup> This research was based upon a questionnaire survey of 100 young doctors and revealed that the majority held a positive attitude towards unconventional therapies. Eighteen of the trainees were already practising either one or a combination of hypnosis, manipulation, acupuncture or homeopathy, and seventy expressed interest in gaining training at a later date. A similar study was undertaken by Wharton and Lewith in

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<sup>41</sup> Fulder, S. J. and Munro, R. (1982). *Op. Cit. No. 9*.

<sup>42</sup> While here I restrict my review to the British context there have been a number of studies which have explored attitudes and practices relating to unconventional therapies amongst conventional doctors in other countries. For example with regard to the US and Canada see Cherkin, D., MacCormack, F. A. and Berg, A. O. (1989). 'Family Physicians' View on Chiropractors: Hostile or Hospitable?'. *American Journal of Public Health* 79: 636-637. Verhoef, M. J. and Sutherland, L. R. (1995). 'General Practitioners' Assessment of and Interest in Alternative Medicine in Canada'. *Social Science and Medicine* 41(4): 511-515. For New Zealand see, Marshall, R. J., Gee, R., Israel, M. *et al.* (1990). 'The Use of Alternative Therapies by Auckland General Practitioners'. *New Zealand Medical Journal* 103: 213-215. And for other countries in Europe see, Stutzer, P. (1978). *Complementary Medicine in Family Practice*. MD Thesis, Albert-Ludwig University. Visser, G. J. and Peters, L. (1990). 'Alternative Medicine and General Practitioners in the Netherlands: Towards Acceptance and Integration'. *Family Practitioner* 7: 227-232. Himmel, W., Schulte, M., and Kochen, M. (1993). 'Complementary Medicine: Are Patients' Expectations being met by their General Practitioners?'. *British Journal of General Practice* 43: 232-235. Velimirovic, B. and Raab, S. (1990). 'Attitudes of Medical Students Towards Alternative Medicine'. *Offentliche Gesundheitswesen* 52(3): 1136-1141. Knipschild, P., Kleijnen, J. and ter Riet, G. (1990). 'Belief in the Efficacy of Alternative Medicine among General Practitioners in the Netherlands'. *Social Science and Medicine* 31(5): 625-626.

<sup>43</sup> Reilly, D. (1983). 'Young Doctors' Views on Alternative Medicine'. *British Medical Journal* 287: 337-339.

1986.<sup>44</sup> A questionnaire sent to 200 qualified GPs in the south of England disclosed that a significant percentage of the sample had already received training in one or more therapy and a larger proportion expressed an interest in gaining such training in the future. The most common therapies being practised by these GPs were manipulation, spiritual healing, homeopathy, hypnosis and herbal medicine. Further study, also conducted in 1986, explored attitudes to complementary medicine amongst GPs in the Midlands.<sup>45</sup> Nicholls and Luton report slightly less practice of unconventional medicines among their doctors than those questioned in other studies, yet they still expose a generally positive attitude amongst GPs towards the therapies and their future provision on the NHS.

From a sample of 222 GPs in Oxfordshire a study conducted in 1987 reported that 16% of the sample practised either one or a combination of the following therapies: manipulation, hypnotherapy, acupuncture, psychotherapy, and homeopathy.<sup>46</sup> Twelve percent of these GPs practising unconventional therapy had received training and 42% of the wider sample wanted further training in some form of therapy.

A questionnaire-based study conducted in 1992 examined the attitude and clinical behaviour of both GPs and hospital doctors towards unconventional medicines in the West Dorset Health District.<sup>47</sup> From a sample of just over 50 GPs

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<sup>44</sup> Wharton, R. and Lewith, G. (1986). 'Complementary Medicine and the General Practitioner'. *British Medical Journal* 292: 1498-1500.

<sup>45</sup> Nicholls, P. A. and Luton, J. E. (1986). *Doctors and Complementary Medicine: A Survey of General Practitioners in the Potteries*. Occasional Paper no. 2. North Staffordshire Polytechnic, Dept. Of Sociology.

<sup>46</sup> Anderson, E. and Anderson, P. (1987). 'General Practitioners and Alternative Medicine'. *Journal of the Royal College of General Practitioners* 37: 52-55.

<sup>47</sup> Franklin, D. (1992). 'Medical Practitioners' Attitudes to Complementary Medicine'. *Complementary Medical Research* 6(2): 69-71.



40% said they would like training in a therapy in the future, 15% already practised one or more therapy and of these doctors six had received formal training in their therapy.

Two years later Perkin *et al.* studied the attitude towards unconventional medicines among GPs, hospital doctors and medical students located within the boundaries of the South West Thames Regional Health Authority.<sup>48</sup> Out of their sample of 87 GPs 20% practised 'other' medicine with acupuncture and homeopathy being the two most common therapies employed.

There are problems associated with calculating the level of interest in and practice of unconventional therapies amongst GPs from such data. These studies have often explored different collections of therapies and this makes comparative analysis difficult. Furthermore, all the studies are local small-scale projects which have failed to attract good response rates.

However, a more recent study conducted in 1995 at the University of Sheffield on behalf of the Department of Health has moved some way towards examining the wider context of integration.<sup>49</sup> The authors of this 1995 research estimate from their study sample that just over twenty percent of practices in England offer some form of direct provision of complementary treatment by a member of the primary health care team. This data does not reveal a precise level of GP direct integrative practice (the primary health care team includes many different members such as practice nurses and physiotherapists all of which may possibly offer unconventional therapies and the practices in the study were nearly all group practices) yet the study estimates a figure in the region of ten percent. Given the data that is available from this and earlier

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<sup>48</sup> Perkin, M., Percy, R. M. and Fraser, J. S. (1994). 'A Comparison of the Attitudes Shown by General Practitioners, Hospital Doctors and Medical Students Towards Alternative Medicine'. *Journal of the Royal Society of Medicine* 87: 523-525.

<sup>49</sup> Thomas, K., Fall, M., Parry, G. and Nicholl, J. (1995). *National Survey of Access to Complementary Health Care Via General Practice*. Sheffield, Medical Care Research Unit, University of Sheffield.

studies discussed in this chapter it would seem sensible to conclude that there is currently a small yet significant number of GPs practising complementary therapies in Britain.<sup>50</sup>

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<sup>50</sup> Along with this rise a number of representative bodies have grown in membership, for example the Faculty of Homeopathy, British Medical Acupuncture Society and the British Society of Medical and Dental Hypnosis. Figures gathered from the odd survey of membership of such organisations also provide indications of the level of practice of these therapies within medical circles. However we should be careful to note that such figures taken from society registers do include all medical professionals and not just general practitioners. For details of some figures relating to the BMAS see Hayhoe, S. (1990). 'Editorial'. *Acupuncture in Medicine* 7(1): 1.



## 1.5 Social Science and Integration

While social scientists have considered the expansion of unconventional medicines, the integration of conventional and unconventional medicines still remains under-researched.<sup>51</sup> The main bulk of the research provides preliminary details of GPs' perceptions and attitudes towards unconventional treatments yet fails to explore issues in depth or to produce sociological analyses of developments regarding integration.

Some social scientists examining integration between the two medicines in the United States have considered why orthodox physicians become interested and involved in unconventional medical practice.<sup>52</sup> Goldstein *et al.* argue that personal experiences, such as those relating to their own periods of illness or that of a close family member, influence practitioners' interest in unconventional therapies.<sup>53</sup> The authors conclude from their study of a sample of so-called holistic and non-holistic physicians in North America that, 'the behaviours, attitudes and motivations of these physicians [self-defined as holistic] appeared to have been influenced by subjective, highly personal experiences which took place outside the world of medicine'.<sup>54</sup> By concentrating on the motivations of individual practitioners, Goldstein *et al.* disregard the importance of the wider professional community in directing the practice behaviour and perceptions of individual doctors.

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<sup>51</sup> As Cant and Sharma write, 'the uptake of complementary medicine by health professionals such as doctors and nurses requires further investigation. The expansion of collaboration between orthodox and complementary practitioners in a number of settings raises interesting issues of inter-professional co-operation', Cant, S. and Sharma, U. (1995). *Op. Cit. No. 13*. p.25.

<sup>52</sup> Goldstein, M. S. *et al.* (1987). 'Holistic Physicians: Implications for the Study of the Medical Profession'. *Journal of Health and Social Behaviour* 28: 103-119.

<sup>53</sup> This style of approach sits comfortably alongside the body of literature relating to the British context which attempts to understand the practice behaviour of GPs more generally by drawing upon social-psychological theory. See Bucks, R. S. *et al.* (1990). 'Towards a Typology of General Practitioners' Attitudes to General Practice'. *Social Science and Medicine* 30(5): 537-547.

<sup>54</sup> Goldstein, M. L. *et al.* (1987). *Op. Cit. No. 52*. p.105.

Back on this side of the Atlantic, a few social scientists have raised a number of interesting questions relating to the integration of unconventional medicines within the NHS environment.<sup>55</sup> The only empirical study has been conducted by Saks, who considers the changing boundaries between conventional and unconventional medicine. He explains integration in terms of the professional strategies of medical collectives to maintain and expand their power and dominance.<sup>56</sup>

To be more specific, Saks sets out to explore and explain what he sees as the contemporary incorporation of acupuncture within the medical profession.<sup>57</sup> He explains how, prior to the late 1970s, the medical profession rejected acupuncture. As Saks indicates, not only did the medical elite oppose acupuncture as practised in the lay sector, but the medical community as a whole also remained hostile to those few doctors who practised the therapy from inside the profession. Moving to an analysis of the period from the late 1970s to the 1990s, Saks identifies a contrary trend. He suggests that in this period the medical profession has 'progressively incorporated

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<sup>55</sup> As Sharma suggests, 'If the widespread incorporation of complementary therapies into the NHS ever becomes an issue, then both patients and practitioners would need to balance the (to my mind undoubted) advantages of wider access against the disadvantage that the opportunity to develop a more flexible and interactive relationship between healer and healed than that which the present NHS context encourages'. Sharma, U. (1994). 'The Equation of Responsibility: Complementary Practitioners and Their Patients'. In S. Budd and U. Sharma (eds). *The Healing Bond: The Patient-Practitioner Relationship and Therapeutic Responsibility*. London, Routledge. p.102. Also see, Sharma, U. (1992). *Op. Cit. No. 1*. Taylor, R. C. (1984). 'Alternative Medicine and the Medical Encounter in Britain and the United States'. In J. W. Salmon (ed.). *Alternative Medicines: Popular and Policy Perspectives*. London, Tavistock. Similar issues have been raised by lay therapists regarding both medical practice of unconventional therapy and any incorporation of lay practitioners into the NHS environment. As Cant and Sharma explain, 'there is evidence of reticence among some groups of practitioners. In particular, there are concerns that the special and more "egalitarian" relationship between the holistic alternative practitioner and the patient may be altered as a result of entry into the NHS'. Cant, S. and Sharma, U. (1995). *Op. Cit. No. 13*. p.25. And elsewhere Sharma herself has endorsed this position: 'if non-orthodox therapists are forced to practise under conditions which are not conducive [to holistic practice] then they will only replicate what is already available under the NHS in a different technical form'. Sharma, U. (1992). *Op. Cit. No. 1*. p.213.

<sup>56</sup> As Saks himself explains, his neo-Weberian perspective on the professions defines '[medical] groups as monopolistic bodies seeking to regulate market conditions in their favour in face of competition from outsiders'. Saks, M. (1994). *Op. Cit. No. 15*. p.84.

<sup>57</sup> While the vast majority of his writing is concerned specifically with the therapy of acupuncture, he has on occasion also written about incorporation in more general terms. See Saks, M. (1994). *Op. Cit. No. 15*.

acupuncture into the orthodox medical repertoire<sup>58</sup> - an incorporation which he claims involves a restricted style of practice, augmented by a continuation of the 'none-too-positive' attitude towards lay practice.

To explain these trends Saks considers professional self-interest.

Professional's outright rejection of acupuncture occurs because it represents a potential threat to their hegemony.<sup>59</sup> Professional self-interest also explains the opposition from within the profession to those few doctors actively encouraging acupuncture treatment and employing these techniques to treat their patients. As Saks writes:

medical acupuncturists were themselves under siege within the profession - most conspicuously from the medical elite. The marginal position in which they found themselves also appears to be best explained in terms of professional self-interests. In this respect, such deviant practitioners can be seen as endangering the interests of those at the apex of the medical hierarchy, especially before the 1970s when they had a firmer commitment to the traditional, wider-ranging application of acupuncture favoured by the expanding number of acupuncturists operating outside the profession. This arguably reinforced the challenge to the knowledge base underlying the dominant position of the profession in general and the more highly rewarded medical elite in particular.<sup>60</sup>

Saks also considers the more recent trend of incorporation of unconventional medicines such as acupuncture. He argues that it is tempting to view the incorporationist approach of the profession over more recent years as a 'progressive erosion of professional dominance'.<sup>61</sup> First he suggests the adoption of acupuncture from within the medical community could be seen as an altruistic response to

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<sup>58</sup> Saks, M. (1994). *Op. Cit. No. 15*. p.184.

<sup>59</sup> Gevitz has outlined the main thrust of this interpretation when he writes 'when such theories [of unconventional therapies] gain significant public support, produce defections from the ranks of established physicians, or lead to the rise of competing healers, the cultural authority behind the established mode of apprehending and treating illness may be seriously weakened. This real or potential threat usually results in a process of self-definition by regular physicians, a corresponding combating of those practitioners who deviate from established norms, and a determined effort to retain or win back the patronage of the laity'. Gevitz, N. (1993). *Op. Cit. No. 7*. p.603.

consumer demand. Second, he also suggests that the dominant position of the profession could be seen to be undermined by medical acupuncturists' legitimization of 'other' medicines as practised by therapists who are in competition with the profession over patients. However, Saks also highlights the 'limited manner' in which integration has been conducted, pointing to the employment of the therapy for a restricted number of medical problems as an addition to conventional techniques, and to the fact that practitioners tend to account for the efficacy of such therapies in terms of scientific Western explanations. As Saks insists of this style of incorporation, because

the limited manner in which incorporation has typically occurred...has minimised the encouragement given to non-medically qualified acupuncturists, with their more challenging Yin-Yang theories and broader ranging applications, while at the same time opening up new territory for the profession, such a strategy has frequently been used in successfully combating threats from without.<sup>62</sup>

Saks therefore claims that both the rejection of acupuncture and the more recent incorporationist stance of the medical profession are ways for the profession to maintain its dominance and power in the field of health care provision. Saks sums up what he calls 'the paradox of incorporation' as follows:

Herein lies the paradox of the contemporary medical incorporation of acupuncture; the form of the medical response to this procedure has significantly changed, while the motive force of professional self-interest underlying this shift of position seems to have remained...the possession of

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<sup>60</sup> Saks, M. (ed.) (1992). *Op. Cit. No. 2*. pp.193-194.

<sup>61</sup> Saks, M. (1994). *Op. Cit. No. 15*. p.88.

<sup>62</sup> Saks, M. (1994). *Op. Cit. No. 15*. p.89. And as Saks explains elsewhere, 'it is argued here that the same pressures that have resulted in the maintenance of the negative response to lay acupuncturists and other unorthodox practitioners in the period since the mid-1970s also help to explain the increasingly incorporationist stance taken by the medical elite towards insiders who practice acupuncture. Admittedly, medical acupuncturists...can be seen to threaten in more substantial manner the position of doctors engaged in conventional practices, both directly and through the potential legitimization of the competing activities of alternative practitioners outside the profession. But these costs seem to be outweighed by the benefits from the standpoint of professional self-interests, especially in light of the terms on which the method has been incorporated into orthodox medicine'. Saks, M. (ed.) (1992). *Op. Cit. No. 2*. pp.196-7.

such chameleon-like qualities is certainly one of the reasons why the medical profession has been so successful to date in defending its interests against competitors in the arena of alternative medicine.<sup>63</sup>

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<sup>63</sup> Saks, M. (ed.) (1992). *Ibid.* p.198.

## 1.6 Redirecting Study

Notwithstanding the sophistication and detail of Saks's analysis, there are dangers with his focus upon the border between the medical profession and practitioners outwith it. First, any divisions or factions within the profession remain unexamined. The interests of the profession are taken as homogeneous; transcending the boundaries of any internal groupings.<sup>64</sup> However, there are likely to be divisions and rivalries between and within different specialisms of the profession. These differences will shape debates and behaviours within the profession and ought to be considered further.

This past work has also tended to place particular attention upon the stance of the medical elite towards unconventional medicines, examining formal documents and journal articles. Given the constraints such as peer review which affect such formal publications, it is likely that confidential interviews with rank and file doctors will encourage more candid discussion of unconventional therapies from within the profession. Furthermore, the fact that the grass-roots of the medical community constitute a key site of enthusiasm about integrative practice<sup>65</sup> which has often been out of tune with the stance of the medical elite,<sup>66</sup> supports a reorientation of research focus to include a detailed investigation of the perceptions and attitudes of ordinary GPs personally practising unconventional therapies within their NHS surgeries.

The attempt to correct these specific deficiencies has provided the driving motivation for the present study, and as such this thesis offers an original sociological

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<sup>64</sup> This point is clearly expressed when Saks refers to those GPs personally practising unconventional therapies as deviant practitioners. While this label maybe appropriate in terms of the wider profession, it is less so when considered in terms of smaller subgroups within the ranks of the medical community.

<sup>65</sup> Nicholls, P. A. (1988). *Op. Cit. No. 2*. p.283.

<sup>66</sup> Sharma, U. (1992). *Op. Cit. No. 1*. p.105.

approach to the study of direct integrative practice. This thesis represents an exploratory study of uncharted territory; the study provides the first in-depth examination of grass-roots GPs' accounts of their direct integrative practice, contextualising their talk not only within the ongoing struggles between the conventional and unconventional communities, but also within more specific intra-professional and inter-professional debates and negotiations. Following this original approach to the study of direct integrative practice obviously guides the methodology employed in this thesis; a brief discussion of the methodology and other key features of the study is provided in the chapter overview outlined in the next section.



## 1.7 Overview of Chapters

In chapter two I outline the thematic framework of the study. It is proposed that the GPs' accounts of their integrative practice and a number of related themes be critically examined in terms of the stories they tell. Building upon some tenets of what has become known as a performative view of language I suggest that attention be focused upon how events, objects and practices are described and presented by doctors. I introduce the concepts of interpretative repertoires and boundary constructions as key analytical units for exploring informants' accounts.

While embracing some features of discursive psychology I explain the need to augment an examination of the local context of language use with an appreciation of wider interpretative communities. In order to meet this need I introduce the analytical framework of social worlds theory (SWT). There is much congruence between certain key features of SWT and those of a number of other sociological perspectives. I illustrate how the works of Gieryn and Bloor from within science studies and of Abbot from within the sociology of professions can be integrated with SWT to produce a rich and productive analytical framework within which to understand the GPs' accounts. I place particular stress upon analysing the boundaries and territories presented in the GPs' talk and upon exploring how these features are integral to the GPs' attempts to justify and authenticate their own practices while dismissing those of other medical groups.

Drawing upon key features of the analytical framework developed within discursive psychology the thesis is based upon in-depth unstructured interviews conducted with GPs practising unconventional therapies in either of the cities of Glasgow or Edinburgh. Chapter three outlines the details of data collection and transcript analysis undertaken in the study.



One specific area of boundary-work identified within the GPs' accounts relates to the border between general practice and the private sector of non-medically qualified therapy. In chapter four I examine how GPs' notions of 'styles' of practice are central to this demarcation between general practice and lay therapy. I outline the diverse range of rhetorical tools employed by the GPs to further distance themselves from both lay therapists and the 'style' of therapy those therapists practise. I consider how GPs authenticate unconventional therapy within general practice while attempting to undermine lay practice. I argue that the GPs' descriptions of lay practice, and their presentations of unconventional therapies more generally, are ways of presenting themselves as essential to good effective unconventional therapy.

Unconventional medical treatments are still administered predominantly outwith the jurisdiction of the medical profession, and the therapies remain a controversial issue within the ranks of general practice. As a result those GPs who initiate direct integrative practice face potential opposition from certain sectors of their professional community, and perceive a need to convince these others of the worth and suitability of unconventional therapies for the general practice environment. Chapter five explores the GPs' presentations of the clinical reality of integrative practice. I outline a number of devices whereby the doctors attempt to translate and re-express these 'other' practices in terms of their own professional culture and explore how this enhances demarcations between GPs and lay therapists.

Yet the GPs' explanations of their integrative practice also play a more positive function for this group of doctors. Chapters six and seven examine the opportunities these therapies offer the GPs in relation to intra-professional and inter-professional struggles and debates. Surveying the GPs' descriptions of their professional identity, chapter six explains how the therapies are employed by the GPs

as a means of appealing to and further legitimating certain professional images. I consider how particular presentations of professional identity aid the GPs' justifications of their unconventional practice. I also explore the GPs' descriptions of and justifications for integrative practice in relation to their construction of a medical role distinct from hospital medicine.

Chapter seven goes on to explore the GPs' portrayal of unconventional medicines in relation to the current controversy surrounding evidence-based medicine. Here I consider the possible role these 'other' medical techniques may play in the GPs' attempts to stave off what they perceive to be the threat of evidence-based medicine to their clinical autonomy and freedom.

The concluding chapter draws together the major findings produced in the analysis. The chapter explains how the thesis contributes to our understanding of the substantive topic of direct integrative practice and also how it provides a critical awareness of certain theoretical perspectives and their suitability to such empirical study. By way of concluding the study I outline some of the limitations of the thesis and propose areas for future research.

## **Chapter Two**

### **Developing a Theoretical Framework**

## 2.1 Introduction

The aim of this chapter is to outline a theoretical framework and demonstrate its suitability to the particular case study in hand. The study builds upon what has become known as a social constructionist approach. However, such an approach harbours many groups of writers and divergent theoretical views<sup>1</sup> and it is acknowledged that this perspective does not represent a homogenous field of study but instead constitutes a number of traditions from a diverse range of disciplines which share ‘family resemblances’.<sup>2</sup> It is not my intention to provide an exhaustive or extensive discussion of these traditions and their influences. Instead a range of underlying assumptions and concepts developed from across this ‘perspective’ are mobilised and incorporated into the theoretical framework formulated here and are examined throughout this chapter; attention is consistently directed to the pragmatic use of analytical concepts and constructs in as far as they help produce an insightful examination of this medical topic.

Following the ‘narrative turn’ within the social sciences over the last three decades,<sup>3</sup> it is proposed that the GPs’ accounts of their integrative practice and a

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<sup>1</sup> Constructionist scholarship includes: ethnomethodology and conversation analysis; post-structuralism, in particular the writings of Foucault; some writers from within the sociology of scientific knowledge; various feminist scholars; the rhetorical psychology of Billig and others; and the ‘new-paradigm’ approach from within social psychology (this group is often labelled ‘discursive psychology’). Also, as will become clearer a little later in this chapter, pragmatist philosophy and symbolic interactionism are also constructivist in some of their underlying themes.

<sup>2</sup> Elston, M. A. (1997). ‘Introduction: The Sociology of Medical Science and Technology’. In M. A. Elston (ed.). *The Sociology of Medical Science and Technology*. Oxford, Blackwell. Burr, V. (1995). *An Introduction to Social Constructionism*. London, Routledge. p.2. Atkinson makes a similar reference to a range of analytical perspectives ‘that differ, but in their various ways they reflect the “linguistic turn” in the human sciences. This tendency has led to varieties of “discourse” analysis, structuralism, post-structuralism and deconstructive criticism’. Atkinson, P. (1990). *The Ethnographic Imagination*. London, Routledge. p.6.

<sup>3</sup> Different authors have used different titles (‘narrative turn’, ‘linguistic turn’, etc.). For example, Simons uses the term ‘rhetorical turn’, see Simons, H. W. (1990). ‘Rhetoric of Inquiry as an Intellectual Movement’. In H. W. Simons (ed.). *The Rhetorical Turn*. Chicago, University of Chicago Press. For an interesting overview of this development relating to sociology see Maines, D. R. (1993). ‘Narrative’s Moment and Sociology’s Phenomena’. *Sociological Quarterly* 34(1): 17-34. This linguistic turn is born out of the rise of what some have called ‘micro-sociologies’ in response to the abstract claims of

number of related themes be critically examined in terms of stories.<sup>4</sup> As a means of outlining this position, section two of this chapter highlights a number of assumptions which have underlined a traditional sociological approach to professional communities, and section three contrasts this approach with the perspectives of discursive psychology and other related methodologies.<sup>5</sup> Building upon some tenets of a performative approach to language attention is directed to how events, objects and practices are described and construed, and section 2.3 explains how concepts of rhetorical tools and interpretative repertoires can be employed to examine informants' accounts of integrative practice.

While stressing the primacy of language in social life, section four moves attention beyond the stories themselves. The thesis moves away from the view, which has been predominant within certain traditions of discourse analysis, that analysis should restrict itself only to the study of texts and that the analyst can do little more than 'just join a discourse about discourse about discourse'.<sup>6</sup> Indeed, the need to contextualise accounts has been tacitly acknowledged within discursive psychology with the identification of linguistic resources such as interpretative repertoires. I wish to augment an examination of the local context of language use with an emphasis upon the wider social relevance of stories. In effect, this means not only detecting the

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normative perspectives within sociology, for example functionalism or Durkheim's methodological collectivism.

<sup>4</sup> This notion of stories refers to the work of a number of writers. Particularly, Plummer, K. (1995). *Telling Sexual Stories*. London, Routledge. Plummer develops and outlines what he calls a sociology of story telling. Also, see Riessman, C. K. (1993). *Narrative Analysis*. London, Sage. It must be noted that writers have employed different titles to refer to informants' talk. I use the terms 'stories' and 'accounts' interchangeably when referring to such talk. To qualify, the use of the title 'stories' does not imply that these descriptions are mere fictions with no relevance to a material world nor is it intended to trivialise the status of the informants talk. As the framework presented in this thesis helps testify stories are far from trivial; stories are in fact deadly serious pertaining to the inequalities of the social order and ultimately to the 'quality' of individuals' lives in that order.

<sup>5</sup> It is noted that discourse analysis is itself a varied field of study. For a brief yet succinct outline of the different types of discourse analysis see Potter, J. and Wetherell, M. (1994). 'Analyzing Discourse'. In Bryman, A. and Burgess, R. (eds). *Analyzing Qualitative Data*. London, Routledge. pp.47-49.

discursive resources utilised by the GPs in their accounts but also exploring how these resources relate to wider interpretative communities and their ongoing struggles and negotiations over meanings and symbolisation. This extension of the *analysts' gaze* requires that we develop a working conception of social structure. Consequently, in order to appreciate the ideological function certain discursive constructions may hold for this particular group of practitioners, the framework of social worlds theory (SWT) is introduced in section 2.5. From within SWT, the particular concepts of claiming worth and legitimacy (and the related processes of attacking the worth and legitimacy of other worlds) are utilised.

There is much congruence between certain features of SWT and those of a number of other sociological perspectives, notably the concepts of territory, boundaries and boundary-work from Gieryn's social cartography; Abbot's work on the jurisdictional struggles and disputes of professional communities; and Bloor's notion of self-referential speech communities. When meshed with aspects from these other perspectives, SWT provides a rich and productive analytical landscape with which to contextualise the GPs' discourse.

This analytical framework helps elucidate how the conceptualisations of different identities, territories and borders within the GPs' accounts are implicitly tied to notions of power and change in the wider medical arena. In addition, this framework also helps overcome some of the difficulties identified in earlier work regarding the topic of unconventional therapies and their integration by sections of the medical community (see chapter one, section six). First, the focus is orientated to grass-roots practitioners and their accounts rather than concentrating solely upon the

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<sup>6</sup> Parker, I. (1992a). 'Discourse Discourse: Social Psychology and Postmodernity'. In J. Doherty, E. Graham, and M. Malek (eds). *Postmodernism and the Social Sciences*. London, Macmillan. p.94.

stance of official bodies representing professional communities. Second, the approach incorporates a sensitivity to the inter- and intra-professional groups within medicine and to the changes which characterise these groupings as they segment, splinter or combine to produce ever new formations.

The chapter ends with an exposition of a number of specific research questions which have been developed in light of the analytical framework explored in this present chapter. These research questions act as a guide to the five analysis and discussion chapters presented later in the thesis.



## 2.2 Critically Examining the Medical Profession: Developing a Constructionist Perspective and Moving Away from a Traditional Sociological Approach to Professional Communities

The social constructionist perspective which has emerged within the social sciences undermines a number of basic assumptions which characterise the 'traditional' essentialist sociological approach to science, medicine and other professional communities which remained dominant up until the late 1960s.<sup>7</sup> Consequently, a good way of introducing the concepts and underlying tenets adopted within this study is to briefly examine some features of this traditional approach and to explore how that perspective differs from the one developed here.

A classic example of the traditional approach to a professional community can be seen in Merton's work within the sociology of science.<sup>8</sup> Merton attempts to address the question of what distinguishes the scientific community from the non-scientific community. In this vein he identifies a range of distinct social norms - communism, disinterestedness, organised scepticism and universalism - which he claims permeate

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<sup>7</sup> For discussion of the traditional approach and its failings with reference to medicine see the now classic text of Wright, P and Treacher, A. (1982). *The Problem of Medical Knowledge*. Edinburgh, Edinburgh University Press. pp.3-11. Saks, M. (1995). *Professions and the Public Interest*. London, Routledge. pp.12-15. For an outline of this tradition with relation to the study of science see Sklair, L. (1973). *Organised Knowledge: A Sociological View of Science and Technology*. London, Hart-Davis, MacGibbon.

<sup>8</sup> Note the use of the title sociology of science rather than sociology of scientific knowledge. This is because Merton's work fails to rigorously examine scientific knowledge in any critical way as will become apparent later in this chapter. As Law suggests, at the time of the ascendancy of Mertonian sociology the sociology of knowledge 'went into decline': Law, J. (ed.) (1987). *Power, Action and Belief*. London, Routledge and Kegan Paul. p.1. The influence that Merton's work had upon sociological studies of science is reflected in the widespread use of the label 'Mertonian approach' to refer to the traditional approach. With reference to this Mertonian approach see Merton, R. K. (1957). 'Priorities in Scientific Discovery'. *American Journal of Sociology* 22: 635-59. Merton, R. K. (1963). 'Resistance to the Systematic Study of Multiple Discoveries in Science'. *European Journal of Sociology* 4: 237-82. Merton, R. K. (1973). *The Sociology of Science*. London, University of Chicago Press.

the scientific community and as a result are seen as explaining the ability of modern science to produce 'credible' knowledge.<sup>9</sup>

A similar project has been developed by some writers with respect to the medical profession.<sup>10</sup> These writers, espousing what has been labelled the taxonomic approach,<sup>11</sup> stress the altruistic nature of the professions (as identified in their service ideal amongst other things) as a means of differentiating them from other occupational groups.<sup>12</sup> In the same way as Merton set out to characterise the attributes of the scientific community, this work within medical sociology 'is based on the compilation of lists of theoretically unrelated sets of attributes, such as extensive knowledge and responsibility, that are seen to represent the central defining features of a profession'.<sup>13</sup> Implicit within these approaches, both from within the sociology of science and the sociology of medicine, are a set of deeper assumptions which have

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<sup>9</sup> Merton, R. K. (1973). *Ibid.* For a concise assessment of these Mertonian norms of science see Gieryn, T. (1995). 'Boundaries of Science'. In S. Jasanoff, G. E. Markle, J. C. Petersen and T. Pinch (eds). *Handbook of Science and Technology Studies*. London, Sage. pp.398-99.

<sup>10</sup> Indeed, work from within the sociology of science has had a strong and lasting influence upon the perspectives of medical sociology. This runs true for both the traditional sociological approach and the more recent critique in the form of constructionist sociologies of science. For comments on this relationship between the two subdisciplines see Elston, M. A. (ed.) (1997). *Op. Cit. No. 2*. p.4-5.

<sup>11</sup> Saks, M. (1995). *Op. Cit. No. 7*. As Saks rightly identifies this taxonomic approach consists of the trait model and Functionalist writings. While these two models do have distinctions more importantly they share some important features towards a study of professions. And as Abbott refers to the Functionalist writings on professions, 'early work on professionalisation had rested on the functional assumptions characteristic of post-war sociology. It attributed the collegial organisation of professions to their position as experts': Abbott, A. (1988). *The System of Professions*. London, University of Chicago Press. p.5. Examples of such early work are, Greenwood, E. (1957). 'Attributes of a Profession'. *Social Work* 2: 44-55. Goode, W. (1960). 'Encroachment, Charlatanism and the Emerging Profession: Psychiatry, Sociology and Medicine'. *American Sociological Review* 25: 902-14, and Parsons, T. (1954). 'The Professions and Social Structure'. In T. Parsons. *Essays in Sociological Theory*. New York, Free Press (originally published 1939).

<sup>12</sup> The basis of this approach was set in the 1930s with the first 'social science' overview and examination of professions generally. See Carr-Saunders, A. P. and Wilson, P. A. (1933). *The Professions*. Oxford, Oxford University Press.

<sup>13</sup> Saks, M. (1995). *Op. Cit. No. 7*. p.12. Gieryn has committed much of his writing to meticulously explaining the demarcation between essentialist and constructivist sociologies of professional communities (of especial interest to him is science). Within this work he outlines the defining feature of an essentialist sociology of science and how it differs from that of the constructivist sociologies. This outline fits comfortably alongside the comment of Saks above. Gieryn states, 'Essentialists argue for the possibility and analytical desirability of identifying unique, necessary, and invariant qualities that set science apart from other cultural practices and products, and that explain its singular achievements (valid and reliable claims about the external world).' Gieryn, T. (1995). *Op. Cit. No. 9*. p.393.

significant, indeed far-reaching, implications for the sociological examination of medical knowledge. Of these assumptions two in particular are pertinent to this discussion.

### 2.2.1 From the Sociology of 'Error' to Symmetry

Society and medical knowledge were regarded as, by their very nature, independent and autonomous domains...Such a standpoint resulted in a curious asymmetry: 'correct', 'effective', forward-looking medical ideas were seen as requiring no explanation; they were the fruits of a dispassionate penetration of the workings of nature. Past knowledge, however, which, by the standards of the historian's own day, appeared incorrect, ineffective, or old-fashioned, was regarded as the product of social causation.<sup>14</sup>

First, the traditional approach has serious repercussions regarding the *scope* of sociological study. Thinking sociologically, so this model proposes, should be directed towards the knowledge that has been deemed 'unsuccessful' and 'rejected' by the professional community itself. While the conventional medical community and its practices are examined in the *restricted* terms of a prescribed institutional framework, the authentic topic for sociological study is ordained to be that which falls outwith the professional medical remit; sociology of science and medicine is to be the 'sociology of error'.<sup>15</sup> Crucially, this position involves an identification, prior to investigation, of the different nature of medical and non-medical knowledge. The distinction between these two categories of knowledge is taken as resting upon assumptions of truth and falsity.<sup>16</sup> The acceptance of certain medical knowledge and associated practices is

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<sup>14</sup> Wright, P. and Treacher, A. (1982). *Op. Cit. No. 7*. p.5.

<sup>15</sup> Potter, J. (1996). *Representing Reality*. London, Sage. p.19.

<sup>16</sup> For a brief review of this feature of the traditional perspective see Parssinen, T. M. (1979). 'Professional Deviants and the History of Medicine: Medical Mesmerists in Victorian Britain'. In R. Wallis (ed.). *On the Margins of Science: The Social Construction of Rejected Knowledge*. Keele, Sociological Review Monograph. No. 27. As Parssinen puts it, 'why has some knowledge been accepted by the medical community and other knowledge rejected? Most historians of medicine have assumed that knowledge-claims are eventually accepted if they correspond to scientific truth, and rejected if they do not. This 'correspondence' view of verification is implicit in the dominant tradition

seen as based upon the objective, solid and factual nature of this knowledge.<sup>17</sup> In contrast, the traditional approach argues, rejected medical knowledge - that which is rejected by the medical profession - acquires such status because it constitutes misrepresentation, contamination and incorporates ideological features.<sup>18</sup> Accepting this dichotomy between the nature of true and false beliefs leads to a 'protective net' being cast over the domain of accepted medical knowledge which shields the field from the sociologist's gaze. In this sense, the sociology of knowledge is divorced from the sociology of science and medicine and, as such, the content of medical knowledge is left unexamined and unchallenged.<sup>19</sup> If accepted knowledge is credible owing to its objective nature then it requires no *social* explanation and the social scientist has no role to play in an investigation of such knowledge.<sup>20</sup> The credibility of medical

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in the history of medicine which conceives of it, at least in modern times, as a march of progress towards truth, led by the discoveries of heroic physician-scientists'. p.103. Also see, Lynch, M. (1993). *Scientific Practice and Ordinary Action*. Cambridge, Cambridge University Press.

<sup>17</sup> As Wright and Treacher explain, the traditional approach to medicine suggested that 'modern medical knowledge was distinctive because it was characterised by two particular features; it was built upon the findings of modern science; and it was effective. Its scientific foundation was important because medicine drew from it the same privileged epistemological status that was usually accorded to science: if science was the accurate reading of Nature's book with eyes undistorted by social interest or cultural prejudice, medicine was the benevolent application of some of what was found there. The history of medicine, in consequence, was frequently expressed in triumphalist terms: as a process of refining; of separating the pure, neutral, scientific essence from everything that had contaminated it'. Wright, P. and Treacher, A. (eds) (1982). *Op. Cit. No. 7*. p.4.

<sup>18</sup> Early sociological studies of unconventional medicine represent classic examples of this approach. A clear example being Wallis and Morley who classify the medicines as 'marginal' and therefore reflect the dominant attitude of the medical profession towards the therapies at this time. Wallis, R. and P. Morley (eds) (1976). *Marginal Medicine*. London, Peter Owen. Also see Aakster, C. W. (1986). 'Concepts in Alternative Medicine'. *Social Science and Medicine* 22(2): 265-273. Aakster uncritically adopts the language and constructs of the medical community as a means of defining and examining alternative medical systems. As Salmon writes, '[the] assumed validity [of western scientific medicine] is so taken for granted in western society that suggestions that other systems of medicine may also have validity are often rejected out of hand. Western superiority in economic, technological, and military spheres has perpetuated the assumption that scientific medicine is likewise far superior to its predecessors and competitors': Salmon, J. W. (ed.) (1984). *Alternative Medicines: Popular and Policy Perspectives*. London, Tavistock. p.3.

<sup>19</sup> As Brown suggests, 'In segregating the sociology of knowledge from the sociology of science...positivists have declared that whatever validity depends upon, it cannot be examined as rhetorical'. Brown, R. H. (1987). *Society as Text*. Cambridge, Cambridge University Press. p.69.

<sup>20</sup> This approach which espouses a lack of concern with the content of credible medical knowledge has strongly influenced medical sociology. The field has effectively (until the late 1960s) steered clear of subjecting conventional medical knowledge to a full sociological analysis. As Lock suggests, 'sociologists, in common with their anthropological colleagues, have until recently rarely made the

knowledge is seen as being dictated by principles of reason and rationality and is conceptualised as an *autonomous process*<sup>21</sup> separate from social practices. Effectively, following this approach, the social analyst can do little else but describe and accept 'credible' medical knowledge and, ultimately, the sociologist is to be little more than the benevolent bedfellow or servant of the professional community 'retelling [medical professionals'] own folk stories'.<sup>22</sup>

Critics of the traditional approach have outlined these features and in response have attempted to develop a *symmetrical* stance to the study of science and medicine.<sup>23</sup> This postulate for sociological study is formulated by Bloor from within

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content of modern medical knowledge itself a subject for analysis, and have tended to rest assured that, because it is supposedly grounded in science, it is not, therefore, a subject for sociological enquiry'. Lock, M. (1988). 'Introduction'. In M. Lock and D. Gordon, (eds). *Biomedicine Examined*, London, Kluwer Academic. p.5. In a similar vein Martin writes of how anthropology (of science and reproductive medicine) in former decades was directed exclusively to 'exotic' other cultures and how this is based upon the notion that western 'scientific' knowledge is true. She states: 'In the years after my fieldwork in Taiwan, the problems anthropologists regarded as central began to undergo change. Far from our earlier suspicion that fieldwork at home was unacceptable because it did not make the exotic become familiar, many anthropologists began to feel that we urgently needed cultural studies of western societies...we began to see that for all our intention of understanding other cultural worlds, as long as our own assumptions - about gender, say - remained unanalysed, they could creep unnoticed into accounts of other places. We were in danger of treating foreign customs and beliefs as in need of explanation or translation and our own as self-evident or, for those aspects of our beliefs we label "scientific," true', Martin, E. (1989). *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston, Beacon Press. p.4. Salmon makes a similar point: 'the form and content of scientific medicine has been widely interpreted to be independent of the social context in which it has developed and presently reigns. It is inherently assumed to have an internally coherent, self-evident, and objective validity': Salmon, J. W. (1984). *Op. Cit. No. 18*. p.3.

Indeed, the demarcation between Mertonian and post-Mertonian sociology of science is often encapsulated in the two titles of strong and weak programmes respectively. While Bloor titled his approach the 'strong programme' and this title is commonly associated with a small group of scholars based at Edinburgh, it is the case that all constructivist sociology of science and medicine represents a 'strong' sociology in as much as it dictates a sociological exploration of scientific and medical knowledge themselves rather than simply rejected and failed knowledge. For use of these titles see Elston, M. A. (1997). *Op. Cit. No. 2*. Some writers within the sociology of medicine and science have argued for the retention and development of a 'weak' programme, see Abraham, J. (1997). 'The Science and Politics of Medicine's Regulation'. In M. A. Elston (ed.). *Op. Cit. No. 2*.

<sup>21</sup> Brown, R. H. (1987). *Op. Cit. No. 19*. p.64.

<sup>22</sup> Potter, J. and Wetherell, M. (1987). *Discourse and Social Psychology*. London, Sage. p.47. Also see Mulkay, M. (1981). 'Action and Belief or Scientific Discourse: A Possible Way of Ending Intellectual Vassalage in Social Studies of Science'. *Philosophy of the Social Sciences* 11: 163-71. Also, with particular reference to the study of the medical profession see Saks, M. (1995). *Op. Cit. No. 7*.

<sup>23</sup> The symmetry postulate (albeit often referred to under a range of titles) can be found in the following texts. Bloor, D. (1976). *Knowledge and Social Imagery*. London, University of Chicago Press. Collins, H. (1981). 'What is TRASP? The Radical Programme as a Methodological Imperative'. *Philosophy of the Social Sciences* 11: 215-24. Berger, P. L. and Luckmann, T. (1967). *The Social Construction of*



the sociology of scientific knowledge who suggests that symmetry 'enjoins us to seek the same kind of causes for both true and false, rational and irrational beliefs'.<sup>24</sup>

Employing the postulate of symmetry (otherwise classified by some writers as the equivalence postulate) requires that we pass no judgement upon the nature of knowledge prior to research but instead treat all knowledge, whether currently accepted or rejected by a professional community, as bound to social practices and processes. As Barnes and Bloor maintain:

our equivalence postulate is that all beliefs are on a par with one another with respect to the causes of their credibility. It is not that all beliefs are equally true or equally false, but that regardless of truth and falsity the fact of their credibility is to be seen as equally problematic. The position we shall defend is that the incidence of all beliefs without exception calls for empirical investigation and must be accounted for by finding the specific, local causes of this credibility.<sup>25</sup>

To direct attention towards the beliefs of the medical profession requires that medical knowledge be conceptualised in a similar fashion to any other more mundane or everyday form of knowledge.<sup>26</sup> While the medical community may claim a special

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*Reality*. London, Penguin. As Berger and Luckmann state, 'It is our contention, then that the sociology of knowledge must concern itself with whatever passes for 'knowledge' in a society, regardless of the ultimate validity or invalidity (by whatever criteria) of such "knowledge"'. p.15. In addition, more recently some writers within medical sociology have incorporated a symmetrical stance to their analysis. With particular reference to unconventional medicine see Power, R. (1991). *The Whole Idea of Medicine*. Unpublished PhD Thesis, South Bank University. And in relation to medical sociology more generally see Bury, M. (1986). 'Social Constructionism and the Development of Medical Sociology'. *Sociology of Health and Illness* 8: 137-169. Nicolson, M. and McLaughlin, C. (1988). 'Social Constructionism and Medical Sociology: A Reply to M. R. Bury'. *Sociology of Health and Illness* 9: 107-126.

<sup>24</sup> Bloor, D. (1976). *Op. Cit. No. 23*.

<sup>25</sup> Barnes, B. and Bloor, D. (1982). 'Relativism, Rationalism, and the Sociology of Knowledge'. In M. Hollis and S. Lukes, (eds). *Rationality and Relativism*. Cambridge, Massachusetts, MIT Press. Collins has outlined a similar position which he terms *methodological relativism*: see Collins, H. (1981). *Op. Cit. No. 23*. Potter explains his understanding of methodological relativism in the following way: 'methodological relativism means that the analyst is not starting with a set of assumptions about what is true and false in any particular social setting and then trying to work out what led some people to get it wrong. Instead, the analyst will be indifferent to whether some set of claims is widely treated by participants as "true" or "false". *Truth and falsity can be studied as moves in a rhetorical game*, and will be treated as such rather than as prior resources governing analysis': Potter, J. (1996). *Op. Cit. No. 15*. pp.40-41.

<sup>26</sup> Ethnomethodology and conversation analysis have clearly illustrated this point. See for example, Atkinson, P. (1981). *The Clinical Experience*. Hampshire, Gower. Pollner, M. (1987). *Mundane*

status for medical knowledge, in terms of its scientific and expert nature, this is to be rejected, or at least suspended from analysis, and 'credible' medical knowledge opened up to critical sociological enquiry.<sup>27</sup> Potter highlights this point when he writes:

One of the most striking consequences of approaching scientific knowledge from a stance of methodological relativism is that it immediately frees up the whole scientific field for study. The social analyst is no longer restricted to picking up the scraps rejected from the scientific table as false beliefs or having to be content with routine studies of its organisational psychology.<sup>28</sup>

While it is the case that symmetry does not necessarily underpin all constructionist work<sup>29</sup> it is a central assumption adopted in this study. Indeed, the particular branch of constructionism developed by discursive psychologists which focuses upon the detailed analysis of participants' accounts assumes a symmetrical approach. As will be outlined shortly, this thesis draws upon this work and as a consequence stresses the fundamental importance of a symmetrical approach to the analysis of the GPs' accounts. Adopting this tenet of symmetry means approaching unconventional medical knowledge (that which is currently excluded from the medical curriculum and practised largely outwith both the NHS and the services offered by members of the medical profession more generally) in a similar fashion to conventional medical knowledge. Questions about the efficacy, worth and legitimacy

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*Reason*. Cambridge, Cambridge University Press. Miller, G. (1990). 'Work as Reality-Maintaining Activity'. *Current Research on Occupations and Professions* 5: 163-183.

<sup>27</sup> As Lock outlines, 'an examination of the social and cultural construction of biomedicine forces a questioning of the privileged status for its knowledge': Lock, M. (1988). *Op. Cit. No. 20*. p.7. Also see Lynch, M. (1993). *Op. Cit. No. 16*.

<sup>28</sup> Potter, J. (1996). *Op. Cit. No. 15*. pp.25-6. Golinski also highlights this implication of adopting a symmetrical approach within the history and sociology of science and medicine. He writes: 'Traditionally, science had been seen as maintained by certain institutions that might be necessary for it to flourish but did not affect the content of what was believed. The constructivist outlook suggests, however, that science is shaped by social relations at its very core - in the details of what is accepted as knowledge and how it is pursued.' Golinski, J. (1998). *Making Natural Knowledge*. Cambridge, Cambridge University Press. pp.17-18.

<sup>29</sup> For example, for criticism of Collins's work relating to this point see Potter, J. (1996). *Op. Cit. No. 15*. pp.30-34.



of the different medicines are not to be answered by the analyst. Instead, these are themes analysed purely in terms of fragments of the wider rhetorical presentations found within GPs' talk.

### 2.2.2 Mirroring Reality and Misrepresentation as Ideology

A second assumption which runs throughout the traditional sociological approach to science and medicine, and which is closely interwoven with the asymmetrical position outlined above, relates to the nature or status of language within the social world. As already explained, the traditional approach supports an unproblematic acceptance of validated medical beliefs. A corollary of this view is the supposition that language can be taken *uncritically*. From the traditional standpoint the credibility of knowledge is to be understood as appertaining to the content of the knowledge itself, and thus language is treated as a *resource* for analysis; the truth of particular beliefs, as expressed and described by the medical profession, is supposedly measured in terms of a correlation with the natural phenomena to which they refer and thus language is seen as a *transparent medium* through which speakers unproblematically record and reflect an external world in terms of happenings, events and practices.<sup>30</sup> As a recent commentator explains through the use of a 'mirror' metaphor:

with the mirror metaphor there are a set of things in the world which are reflected onto a smooth surface, but in this case the surface is not glass but

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<sup>30</sup> As Riessman puts it, 'Language is viewed as a transparent medium, unambiguously reflecting stable, singular meanings': Riessman, C. K. (1993). *Op. Cit. No. 4*. p.4. Also Wetherell and Potter outline the approach of what they call 'an old-fashioned' view of language: '[it] assume[s] that language acts as a neutral, transparent medium between the social actor and the world, so that normally discourse can be taken at face value as a simple description of a mental state or an event. People's utterances might occasionally be distorted by the desire for social desirability but these cases of distorted discourse are unusual. More often, accounts are taken to be simple non-intrusive, neutral reflections of real processes located elsewhere'. Wetherell, M. and Potter, J. (1988). 'Rhetoric and Ideology'. In C. Antaki (ed.). *Analysing Everyday Explanations: A Casebook of Methods*. London, Sage. p.168.

language. Language reflects how things are in its descriptions, representations and accounts. And as these are circulated in the world of human affairs they may be treated as accounts which are reliable, factual or literal, or, alternatively, the mirror may blur or distort in the case of confusions or lies. This metaphor is familiar in stories about science and a whole range of more 'mundane' human practices. It is a metaphor which makes descriptions passive: they merely mirror the world. Yet like a mirror image or a photograph, they can also stand in for that world and be as good as the world for many purposes.<sup>31</sup>

Adopting this tenet, social science has traditionally involved collecting and examining the content of participants' accounts as a means of empirically analysing the culture and practices of professional communities outwith the interview itself.<sup>32</sup> Of course, there has been an acknowledgement that subjects' accounts may not always be reliable or truthful; it is, for example, noted that descriptions may be incomplete and that some may be influenced by self-interest and ideology. Nonetheless, provided researchers make themselves aware of these imperfections and make appropriate adjustments<sup>33</sup> then participants' accounts are seen to provide *descriptions* of background culture.

<sup>31</sup> Potter, J. (1996). *Op. Cit. No. 15*. p.97. For discussion of a similar use of metaphor, in this case the metaphor of 'mapping' see Grace, G. W. (1987). *The Linguistic Construction of Reality*. London, Croom Helm.

<sup>32</sup> See Potter, J. and Mulkay, M. (1982). 'Scientists' Interview Talk: Interviews as a Technique for Revealing Participants' Interpretative Practices'. In M. Brenner, (ed.). *The Research Interview: Uses and Approaches*. London, Academic Press. As Potter and Mulkay put it, 'For the most part interviews are used as a technique for obtaining information that will enable the analyst to describe, explain, and/or predict social actions that occur outside the interview' (p.247). Also see, Rosenwald, G. C. and Ochberg, R. L. (1992). 'Introduction: Life Stories, Cultural Politics, and Self-Understanding'. In G. C. Rosenwald and R. L. Ochberg (eds). *Storied Lives: The Cultural Politics of Self-Understanding*. New Haven, CT, Yale University Press. Gilbert and Mulkay also illustrate this traditional social science approach. They outline a number of steps in such work. These are: '(1) Obtain statements by interview or by listening to or observing participants in a natural setting. (2) Look for broad similarities between the statements. (3) If there are similarities which occur frequently, take the statements at face value, that is, as accurate accounts of what is really going on, and present this as one's own analytical conclusion.' Gilbert, G. N. and Mulkay, M. (1984). *Opening Pandora's Box*. Cambridge, Cambridge University Press. p.5.

<sup>33</sup> An example of such adjustments is found in behavioural psychology where 'experiments' are formulated in an attempt to eradicate unwanted variables, and, in sociology, where there has been the attempt to remain objective and value-neutral. This has involved attempting to make the researcher invisible in his/her work. See Traweek, S. (1992). 'Border Crossings: Narrative Strategy in Science Studies and Among Physicists in Tsukuba Science City, Japan'. In A. Pickering (ed.). *Science as Practice and Culture*. Chicago, Chicago University Press. In support of this point Riessman claims that

Accompanying this traditional sociological approach to language we can identify a particular conception of ideology. The notion of ideology has a long history within social science. In particular, the development of the concept is indebted to the Marxist tradition of thought - both the original writings of Marx and Engels<sup>34</sup> and the work of more recent Marxist thinkers.<sup>35</sup> Marxist traditions conceive of ideology as the imposition of a reflection upon the world which conceals, distorts and obscures the real class relations and interests which underpin capitalist society.<sup>36</sup> In this sense, Marxist formulations of ideology fall into the trap of 'asymmetry' and can be seen to incorporate the traditional approach to language outlined earlier. These writers assert that certain knowledge or claims to knowledge are truthful while others (perpetuating false consciousness) are falsehoods. This leads social science back to an understanding of the potential of informants' language to merely reflect and describe an external real world. As Wetherell and Potter explain a Marxist approach to ideology:

ideology becomes seen as a sort of temporary messiness mixed in with other social practices, a contingent complication in the lives of social actors, and a complication in analyses of social relations; but it is also assumed that with non-ideological understanding the surface can be wiped clean to afford a veridical representation, one which lets the real objects once more emerge.<sup>37</sup>

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'subjectivity...is deeply mistrusted in mainstream social science, which values context-free laws and generalised explanations'. Riessman, C. K. (1993). *Op. Cit. No. 4*. p.5.

<sup>34</sup> Marx, K. and Engels, F. (1970). *The German Ideology*. London, Lawrence and Wishart.

<sup>35</sup> In particular Gramsci, A. (1971). *Prison Notebooks*. London, Lawrence and Wishart. Althusser, L. (1971). *Lenin and Philosophy and Other Essays*. London, NLB. Althusser, L. (1979). *For Marx*. London, Verso.

<sup>36</sup> Billig, M. (1982). *Ideology and Social Psychology*. Oxford, Blackwell. Law, J. (ed.) (1986). *Op. Cit. No. 8*. p.4. This conceptualisation views ideology as error. See Potter, J. (1996). *Op. Cit. No. 15*. The dominance and influence of this approach to ideology within the social sciences can be seen in the negative connotations still associated with the concept in more recent times. For an example of a Marxist approach to the medical profession see Navarro, V. (1979). *Medicine Under Capitalism*. London, Croom Helm.

<sup>37</sup> Wetherell, M. and Potter, J. (1992). *Mapping the Language of Racism*. London: Harvester Wheatsheaf. p.62. Wetherell and Potter explain elsewhere in this text how Marxist writings present ideology as 'a sticky layer between the observer and social reality'. They write, 'either a given representation will accurately reflect, capture and describe real social conditions, presenting reality as it actually is; or a representation will falsify that reality, distorting, obscuring and clouding real conditions'. p. 32.

In contrast, discourse analysts and other related writers support a symmetrical approach to the examination of language and thus, in effect, abandon any negative connotations previously associated with the concept of ideology. All talk contains ideological dimensions. This position rests upon an acknowledgement that all accounts are the constructions of speakers and therefore rest upon interpretation rather than simply reflections of the world; all discourse has an inescapable and essential 'action orientation'.<sup>38</sup>

Building upon constructionist work, this study conceptualises language as having a very different role in social life and therefore a different status in social inquiry. Rather than relegating the role of language to that of resource, which provides a 'snapshot' of some other social phenomena under study, it instead promotes language to the forefront of investigation. Here, the use and construction of language become a *topic* of analysis.<sup>39</sup> To introduce this radical reconceptualisation of language requires an in-depth exploration of participants' accounts of their professional culture, territory and borders. In this thesis the doctors' accounts are examined by utilising some analytical tools and procedures from within discursive psychology. These are explored in the next section.

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<sup>38</sup> Wetherell, M. and Potter, J. (1988). *Op. Cit. No. 30*. Potter, J. (1996). *Op. Cit. No. 15*. Heritage, J. C. (1984). *Garfinkel and Ethnomethodology*. Cambridge, Polity Press.

<sup>39</sup> As Mulkay has argued this focus upon language as a topic of social investigation does not necessarily deny the cultural norms of a professional community such as those suggested by Merton with regard to science. Instead, it means reinterpreting the status of such themes. Instead of proposing that norms such as disinterestedness and communism are intrinsic characteristics of professional practice they can be analysed as rhetorical constructions presented by scientists (and possibly members of the medical scientific community) as a means of legitimating their practices to others. For discussion of this point see Mulkay, M. (1980). 'Interpretation and the Use of Rules: The Case of the Norms of Science'. In T.

### 2.3 Deconstructing Accounts: Language as a Topic and a Focus upon the Story

Nature and the world do not tell stories, individuals do. Interpretations are inevitable because narratives are representations.<sup>40</sup>

From within the broad collection of perspectives which contribute to the constructionist project there is much work which focuses primarily upon the rhetorical construction of accounts of natural and social reality. Rather than examining the contents of stories as an attempt to directly examine the social world of actors, this work conceptualises informants' accounts as the ways in which speakers make sense of events and behaviours to themselves and to others.<sup>41</sup> What is of interest here is the appreciation that we cannot simply ignore the form of a story and investigate descriptions purely as a means of exploring those events, behaviours and situations to which talk is orientated. Instead, it is proposed that the way speakers construct their stories is inseparable from the content of their talk and investigating *how* accounts are told becomes a prime objective for analysis.

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Gieryn (ed.). *Science and Social Structure: A Festschrift for Robert. K. Merton*. New York, New York Academy of Sciences.

<sup>40</sup> Riessman, C. K. (1993). *Op. Cit. No. 4*. p.2.

<sup>41</sup> Horobin and McIntosh acknowledge this position with regard to their now classic study of general practice undertaken in 1977. They write, 'We've come to regard the things that doctors told us not as more or less adequate descriptions of what they did, but rather as attempts jointly with us (the interviewers) to make reasonable (rationalise) general practice as a job': Horobin, H. and McIntosh, J. (1977). 'Responsibility in General Practice'. In M. Stacey, M. Reid, C. Heath and R. Dingwall (eds). *Health and the Division of Labour*. London, Croom Helm. p.108. Other writers have outlined this position to accounts in more general terms (not in direct relation to studying medicine or general practice therein). As Wetherell and Potter claim of discourse analysis developed within the sociology of scientific knowledge, 'it was concerned less with the traditional sociological question of how "social factors" influence acts such as theory choice than with exploring how scientists construct their talk and texts to display their acts as rational and warrantable in any particular setting': Wetherell, M. and Potter, J. (1988). *Op. Cit. No. 30*. p.172. Also see Mulkay, M., Potter, J. and Yearley, S. (1983). 'Why an Analysis of Scientists' Discourse is Needed'. In K. Knorr-Cetina and M. Mulkay (eds). *Science Observed: Perspectives in the Social Study of Science*. London: Sage. Gusfield, J. (ed.) (1989). *Kenneth Burke: On Symbols and Society*. Chicago, Chicago University Press. Wuthnow, R. (1987). *Meaning and Moral Order: Explorations in Cultural Analysis*. Berkeley, University of California Press.



### 2.3.1 Interpretative Repertoires as a Basic Unit of Analysis

In order to help direct such an investigation the concept of interpretative repertoires as promoted by discursive psychologists is built upon here.<sup>42</sup> Repertoires are a basic analytical tool which are located at the very core of an endeavour to deconstruct speakers' accounts and they refer to 'relatively internally consistent, bounded language units'.<sup>43</sup> Wetherell and Potter provide a clear and informative description of these units when they write:

Repertoires can be seen as the building blocks speakers use for constructing versions of actions, cognitive processes and other phenomena. Any particular repertoire is constituted out of a restricted range of terms used in a specific stylistic and grammatical fashion. Commonly these terms are derived from one or more key metaphors and the presence of a repertoire will often be signalled by certain tropes or figures of speech.<sup>44</sup>

While acknowledging and indeed making use of the inconsistencies and variations within and between accounts, discursive psychologists highlight patterns in talk through their identification of interpretative repertoires. In effect, this model of analysis takes inconsistencies and differences across accounts as an area of pivotal analytical focus by contextualising them in terms of repertoires which provide a systematic framework for variations.<sup>45</sup> These dual features of language (variations and patterns) provide a link between discursive psychology and various sociological

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<sup>42</sup> The notion of interpretative repertoires was first introduced by Gilbert and Mulkay in 1984. See Gilbert, N. and Mulkay, M. (1984). *Op. Cit. No. 32*. For an outline of this unit of analysis as described by later writers see Wetherell, M. and Potter, J. (1988). *Op. Cit. No. 30*. McInlay, A. and Potter, J. (1987). 'Model Discourse'. *Social Studies of Science* 17: 443-463.

<sup>43</sup> Wetherell, M. and Potter, J. (1988). *Op. Cit. No. 30*. p.172.

<sup>44</sup> Wetherell, M. and Potter, J. (1988). *Ibid.* p.172.

<sup>45</sup> As Wetherell and Potter explain, '[A] repertoire is a resource which the analyst can identify as a recurring pattern in the content of certain materials': Wetherell, M. and Potter, J. (1988). *Ibid.* p.173. And Potter writes of repertoires as 'systematically related sets of terms, often used with stylistic and grammatical coherence, and often organised around one or more central metaphors. They are one of the major resources that [speakers] use when constructing versions of the world': Potter, J. (1996). *Op. Cit. No. 15*. p.116.

perspectives and this is a link which will be outlined in more detail a little later in this chapter.

### **2.3.2 Boundary Construction**

Turning to the work of Gieryn from within science studies we can identify another basic analytical unit which complements the focus upon interpretative repertoires. Gieryn, interested in analysing the demarcation between science and non-science as presented within the accounts of scientists themselves, has introduced the concept of boundary construction.<sup>46</sup> It is suggested that analysts examine professionals' accounts in their search for the borders where one professional world ends and another begins. Obviously episodes of boundary construction intertwine with speakers' selective use of interpretative repertoires; repertoires form the basic tool with which boundaries are manufactured with one group being associated with one or a number of repertoires and another group being characterised by means of a different or contrasting set of repertoires. As such, in this thesis analysing the boundary constructions within the GPs' talk will run alongside the examination of interpretative repertoires.

### **2.3.3 The Performative Nature of Talk**

Thus identifying interpretative repertoires and boundary constructions can form the basis for an analysis of informants' accounts. However, deconstruction is only part of the sociological project. Underlying the work of discursive psychologists and other related writers is a notion of the performative nature or action orientation of

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<sup>46</sup> For a more detailed discussion of the concept of boundary construction see Gieryn, T. (1995). *Op. Cit. No. 9*.



talk;<sup>47</sup> language ‘is not merely descriptive...not just trying to tell people how things are. It is trying to *move* people’.<sup>48</sup> In other words, language construction is not simply *saying*; it is also *doing*, it is a *social practice in itself*.<sup>49</sup> Consequently, from this viewpoint sociological attention should be paid not only to the rhetorical construction of stories but also to the question, why this particular telling rather than alternative tellings?

One particular interpretative task which has attracted much investigation from within discursive psychology is the way speakers present their descriptions of the world as the way it is (this can take the form of both conscious strategy and taken-for-granted assumptions). Potter has paid particular attention to this interpretative task within accounts and it is useful to draw upon his recent work to outline this feature of talk.<sup>50</sup> Potter concentrates upon providing an ‘account of the sorts of devices and procedures that contribute to the sense that a discourse is literally describing the world’.<sup>51</sup> Following this aim Potter calls for a dual focus upon stories, taking into account both the *ironizing* and also the *reifying* processes within accounts. Reifying discourse is that which projects descriptions as factual, literal and solid. In contrast, the ironizing dimension of accounts relates to that talk which construes the descriptions of others as based upon either strategy or interests. These categorisations complement Gilbert and Mulkay’s outline of empiricist and contingent repertoires

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<sup>47</sup> See Wetherell, M. and Potter, J. (1988). *Op. Cit. No. 30*. Potter, J. (1996). *Op. Cit. No. 15*. McInlay, A. and Potter, J. (1987). *Op. Cit. No. 42*. And from within the tradition of ethnomethodology see Heritage, J. C. (1984). *Op. Cit. No. 38*.

<sup>48</sup> Burke, K. (1950). *A Rhetoric of Motives*. New York, Prentice Hall. Likewise Riessman has pointed to the persuasion inherent in narratives. She writes, ‘every good narrator tries to defend against the implicit assertion of a pointless story, warding off the question: “so what?”’: Riessman, C. K. (1993). *Op. Cit. No. 4*. p.20. And as McInlay and Potter point out, ‘discourse is actively used for many purposes over and above merely describing things’: McInlay, A. and Potter, J. (1984). *Op. Cit. No. 42*. p.444.

<sup>49</sup> Wetherell, M. and Potter, J. (1988). *Op. Cit. No. 30*. p.168.

<sup>50</sup> Potter, J. (1996). *Op. Cit. No. 15*.

<sup>51</sup> Potter, J. (1996). *Ibid.* p.88.

from their analysis of scientists' accounts; an empiricist repertoire being 'organised in a manner which denies its own character as an interpretative product and which denies that its author's actions are relevant to its content',<sup>52</sup> and a contingent repertoire presenting the descriptions of others as based upon 'their personal inclinations and particular social positions'.<sup>53</sup>

Now, what is of pertinence to the discussion here is the fact that these formulations of the performative dimensions of talk are primarily directed towards interpretative accomplishments within the *locale of the interpersonal*. While this persuasion has wider repercussions beyond the situational context - and this is not denied by writers such as Potter and Wetherall - this is not of particular concern to discursive psychologists.

Discursive psychology, being heavily influenced by conversation analysis, attempts to unravel the complexities of particular interactional tasks and it thus concentrates attention upon such features of talk as pauses, repairs, emphases, repetition of words, and disclaimers.<sup>54</sup> However this is not the primary aim of this thesis. Here, with a broader scope than simply the interpretative tasks of the locale, emphasis is placed upon wider units of talk; interest is primarily in analysing the style and content of ideological claims within and across professional boundaries. This does not mean the discourse analysis conducted by such writers as Wetherell and Potter is negated. Quite the opposite; their analysis is both fruitful and groundbreaking, but the

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<sup>52</sup> Gilbert, N. and Mulkay, M. (1984). *Op. Cit. No. 32*. p.56.

<sup>53</sup> Gilbert, N. and Mulkay, M. (1984). *Ibid.* p.57. It is interesting to note how these processes of reification and ironisation as found in actors' accounts highlight the correspondence of approach between traditional sociological perspectives of professional community and the presentations of the professionals themselves. As explained in the opening sections of this chapter, traditional social science approaches to professions failed to critically examine the presentations of professional actors and as a result these sociologists mirror the idea of science and medicine as divorced from social practices; in effect, both professional actors and traditional sociological studies of science and medicine reified accepted knowledge and ironised competing rejected knowledge.

<sup>54</sup> Potter, J. (1996). *Op. Cit. No. 15* represents a good example of such work.

point is one of focus and emphasis. While acknowledging the situational interpretative tasks that speakers accomplish within their accounts I nonetheless choose to focus upon the tasks of language which are related to circumstances further afield, namely professional rivalries and tensions within the medical arena. As the remaining sections of this chapter explain, the justification for this extension of analytical scope is actually implicit within the works of discourse analysts themselves. Moreover, key concepts from various sociological perspectives can complement and extend the analytical approach to accounts beyond that usually adopted by discursive psychology, thus helping to develop a broader understanding of the social nature of talk.

## 2.4 Moving Beyond the Topic of Stories: A Social Orientation to Discourse

The study of the dynamics which structure texts has to be located in a account of the ways discourses reproduce and transform the material world.<sup>55</sup>

To the sociologically orientated investigator, studying narratives is...useful for what they reveal about social life - culture 'speaks itself' through an individual's story.<sup>56</sup>

The task here is to unpack the types, the languages, the tropes at work inside the text of a...story. But for the sociologist it must go further. The genres and structure of story telling may also link to the generic social processes and structures at work in social life.<sup>57</sup>

So far, this chapter has focused upon work which examines the construction of accounts with a view to their *situational context*. In line with the discourse analysis of social psychologists - as influenced by ethnomethodology, semiotics and other traditions - emphasis has been upon the rhetorical methods and procedures through which actors' descriptions accomplish tasks relating to the locale of talk production. As I have suggested, such deconstruction can provide the building blocks with which to examine GPs' accounts of their integrative practice. However, to leave the analysis at this level would fail to appreciate the wider role that language plays in social life. In effect, while rightly focusing upon the constructive and interpretative nature of stories, any notion of *the social* has momentarily slipped away from view. The approach of discursive psychology is framed by a reinforcement of the view - traditionally associated with social psychology more generally as a discipline - that 'the essential "reality" of discourse lies at the interpersonal level'.<sup>58</sup> Now, this position rightly transcends a perspective of methodological individualism. It does for example tacitly acknowledge the institutional or collective origin of meaning. However, in its place is

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<sup>55</sup> Parker, I. (1992b). *Discourse Dynamics*. London, Routledge. p.1.

<sup>56</sup> Riessman, C. K. (1993). *Op. Cit. No. 4*. p5.

<sup>57</sup> Plummer, K. (1995). *Op. Cit. No. 4*. p.24.

<sup>58</sup> Parker, I. (1992a). *Op. Cit. No. 6*. p.89.

posited methodological situationalism.<sup>59</sup> The principle behind methodological situationalism should not be rejected; the call to analyse social structure and culture through an examination of the interaction and language of actors is supported here. However, this approach presents 'too weak a conception of social structure';<sup>60</sup> rather than simply assuming the existence of linguistic tools and resources it is necessary for the purposes of this thesis to undertake a detailed study of how these tools and resources are inextricably linked to the wider collective units of social life. Michael has provided a clear outline of how methodological situationalism falls short of adequately examining the social beyond texts. He writes of this approach:

the aim is to uncover how [textual commodities] are put together and deployed in micro-situations to achieve particular ends, often self-presentational ... however, how such discourses managed to get in place - that is, to become part of people's repertoires - is left unexplicated. There seems to be a tacit assumption that they are just there - in the tradition, in the collective, in the milieu.<sup>61</sup>

Mention of the 'wider context' of discourse can be found in the work of Wetherell and Potter from within discursive psychology.<sup>62</sup> They state with reference to their study of race relations in New Zealand:

we wanted to look at how our sample's practical reasoning about race might justify and work to maintain asymmetrical power relations between the majority and minority groups, rationalising and naturalising a certain kind of status quo...needless to say, when discourse analysis is used with these kind of goals it must be combined with a careful analysis of the particular intergroup situation in question. *Discourse patterns must be located within an account of their wider context.*<sup>63</sup>

<sup>59</sup> For a detailed discussion of methodological situationalism see Knorr-Cetina, K. and Cicourel, A. (eds) (1981). *Advances in Social Theory and Methodology: Toward an Integration of Micro- and Macro-Sociologies*. Boston, Routledge and Kegan Paul.

<sup>60</sup> Porter, S. (1993). 'Critical Realist Ethnography. The Case of Racism and Professionalism in a Medical Setting'. *Sociology* 27(4): 591-609. p.593.

<sup>61</sup> Michael, M. (1996). *Constructing Identities*. London, Sage. pp.7-8.

<sup>62</sup> Wetherell and Potter (1992). *Op. Cit. No. 37*. A similar point can be found in other works within this tradition of social psychology. See Potter, J. and Wetherell, M. (1987). *Op. Cit. No. 22*. As they suggest in this text, 'the discourse analyst is after the answers to social or sociological questions rather than linguistic ones': p.48.

<sup>63</sup> Wetherell, M. and Potter, J. (1988). *Op. Cit. No. 30*. p173.

Elsewhere in this text, and linked to this same point, Potter and Wetherell explain how their formulation of discourse analysis entails adopting aspects of both situational context and 'wider purposes of discourse'.<sup>64</sup> They write:

we can think of a continuum from more 'interpersonal' function such as explaining, justifying, excusing, blaming and so on, which define the local discursive context, to the wider purposes discourse might serve - where, for instance, a social analyst might wish to describe an account, very broadly, as having a particular level of ideological effect in the sense of legitimising the power of one group in a society.<sup>65</sup>

As Fairclough has emphasised, while Wetherell and Potter advocate the importance of considering 'wider context' when investigating participants' accounts (this is signified through their development and employment of the analytical unit of interpretative repertoires),<sup>66</sup> there is no indication as to how this context may be formulated and analytically explored (i.e. there is no suggestion as to how wider collective units are to be conceptualised); their perspective 'is insufficiently developed in its social orientation to discourse'.<sup>67</sup> Potter and Wetherell are cautious about not reifying social structure,<sup>68</sup> thus they keep their analysis in check and, while acknowledging the structures of inequality, provide only a weak conception of these structures.<sup>69</sup> Despite their apprehension about making the leap from an analysis of text to conceptions of a wider social order, it is, however, possible to build upon Potter

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<sup>64</sup> Wetherell, M. and Potter, J. (1988). *Ibid.* p.169.

<sup>65</sup> Wetherell, M. and Potter, J. (1988). *Ibid.*

<sup>66</sup> This acknowledgement follows the identification by Wetherell and Potter of systematic variation within accounts. For discussion of this point see Fairclough, N. (1992). *Discourse and Social Change*. Cambridge, Polity Press. p.68.

<sup>67</sup> Fairclough, N. (1992). *ibid.* p.25.

<sup>68</sup> For an interesting discussion from within social psychology as to the status and legitimacy of wider context and of analytical categories outside talk itself see Antaki, C. (1994). *Explaining and Arguing*. London, Sage.

<sup>69</sup> While Potter and Wetherell (and other discursive psychologists) attempt to move beyond conversational analysis, their work highlights the strong influence of ethnomethodology upon their approach. This is nowhere more clearly visible than in this weak notion of social structure. The resistance to look beyond the locale of occasioned usage is exemplified in such conversational analysis. For example, see Atkinson, J. M. and Heritage, J. (1984). *The Structure of Social Action*. Cambridge, Cambridge University Press.



and Wetherell's basic observation regarding the contextualisation of language. Indeed, many writers interested in rhetorical construction and language use have emphasised the importance of moving beyond the text<sup>70</sup> and developing a 'social orientation' to language.<sup>71</sup>

There are a number of important issues which inform an analytical gaze beyond the 'local' context of language use. One such issue links to the argumentative and performative nature of language: accounts are not simply ways of telling; they are, more importantly, also attempts to persuade. As outlined earlier, this approach to language sensitises us to the need to analyse rhetorical claims and constructs with reference to contrasting constructs and counter-claims. Ultimately, these positions and counter-positions 'occur within a wider social patterning'<sup>72</sup> and require an investigation not just of texts but also of their location within wider ongoing 'ideological struggles for meaning'.<sup>73</sup> As Billig points out:

we cannot understand the meanings of a piece of reasoned discourse, unless we know what counter-positions are being implicitly or explicitly rejected...the

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<sup>70</sup> See Parker, I. (1992b). *Op. Cit. No. 55*. Fairclough, N. (1992). *Op. Cit. No. 66*. Plummer, K. (1995). *Op. Cit. No. 4*. Kerr, A., Cunningham-Burley, S. and Amos, A. (1997). 'The New Genetics: Professionals' Discursive Boundaries'. *The Sociological Review* 45(2): 279-303. Lock, M. (1988). *Op. Cit. No. 20*. As Lock suggests, 'a balanced description is needed in the case of medical beliefs, not only of ideas about causation and healing, but of who creates and defines these meanings and what significance this has for the allocation of responsibility for the occurrence of illness and for the restoration and maintenance of the social order': p.5. Likewise, Fairclough outlines a similar concern for a sociology of discourse: 'the central concern is to trace explanatory connections between ways in which texts are put together and interpreted, how texts are produced, distributed and consumed in a wider sense, and the nature of the social practice in terms of its relation to social structures and struggles': Fairclough, N. (1992). *Op. Cit. No. 66*. p.72.

<sup>71</sup> Fairclough, N. (1992). *Ibid.* p.4. As Fairclough states elsewhere in this text, 'the discursive constitution of society does not emanate from a free play of ideas in peoples' heads but from a social practice which is firmly rooted in and orientated to real, material social structures': p.66. Also Parker suggests 'we need a sense of wider cultural dynamics' when analysing discourse. Parker, I. (1992b). *Op. Cit. No. 54*. p.22.

<sup>72</sup> Billig, M. (1991). *Ideology and Opinions: Studies in Rhetorical Psychology*. London, Sage. p.18.

<sup>73</sup> Langellier, K. M. (1989). 'Personal Narratives: Perspectives on Theory and Research'. *Text and Performance Quarterly* 9(4): 243-276. p.268. Potter and Wetherell point out how rhetorical psychology helps bring wider considerations into sharper focus. They write, 'rhetorical analysis has been particularly helpful in highlighting the way discursive versions are designed to counter real or potential alternatives. Put another way, it takes the focus of analysis away from questions of how a version relates to some putative reality and asks instead how this version is designed successfully to compete with an alternative'. Potter, J. and Wetherall, M. (1987). *Op. Cit. No. 22*. p.48.



meaning of a piece of reasoned discourse...does not reside in the aggregation of dictionary definitions of the words used to express the position: it also resides in the argumentative context.<sup>74</sup>

This position is further supported by post-structuralist work (and some writers within discursive psychology who have partly built upon that approach), which has identified how discourses - or, in other words, the application of the resources of interpretative repertoires - sustain certain social practices.<sup>75</sup> In particular, this work helps illustrate the link between the way language is employed and constructed by speakers and the perpetuation of concrete social practices and regimes in wider society.

These issues highlight the necessity of a political approach to an examination of story construction. As Mumby proclaims, 'storytelling is not simple representing of a pre-existing reality, but is rather a politically motivated production of a certain way of perceiving the world which privileges certain interests over others'.<sup>76</sup> Thus, if we turn to the case study at hand, we can acknowledge that to construe unconventional therapies in a certain way can be seen as a part of the wider processes of competition, negotiation and conflict whereby groups attempt to monopolise 'a mode of representation' - gain epistemic authority - and thereby restrict and inform the interpretations and meanings that are attached to the practice of such medicines. In

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<sup>74</sup> Billig, M. (1991). *Op. Cit. No. 72*. p.44. For a similar stance see Dillon, G. L. (1991). *Contending Rhetorics: Writing in Academic Disciplines*. Bloomington, Indiana University Press. Potter writes of this position: 'put at its simplest, one of the features of any description is that it counters - actually or potentially - a range of competing alternative descriptions': Potter, J. (1996). *Op. Cit. No. 15*. p.106.

<sup>75</sup> Potter, J., Wetherell, M. and Edwards, D. (1990). 'Discourse: Noun, Verb or Social Practice?' *Philosophical Psychology* 3: 205-17. Also see Coward, R. (1984). *Female Desire*. London, Paladin.

<sup>76</sup> Mumby, D. K. (1987). 'The Political Function of Narrative in Organisations'. *Communication Monographs* 54: 113-127. p.114. Also see Parker, I. (1992b). *Op. Cit. No. 55*. As Parker suggests, without attending to the political context of discourse an analysis 'could become just another method, just an academic exercise': p.1. Porter also cautions against an apolitical approach which strictly adheres to the situational context of action and consequently denies the importance of social structure in analysis. He writes: 'by ignoring the possible constraining nature of social structure commentators are in danger of giving consent, through silence, to their oppressive effects'. Porter, S. (1993). *Op. Cit. No. 60*. p. 596. In addition, Langellier reflects a similar fear of an apolitical examination of personal narratives. Thus he claims, 'to be ethically responsible in studying personal narratives, researchers must take care not to reproduce in scholarship the social differences - gender, race, class, ethnicity, sexual

order to fully expose this political context of discourse we need to first turn our attention to another feature of stories - what writers have termed the paradox or the dualistic nature of language.<sup>77</sup>

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preference, etc. - that mark Otherness and participate in oppressive systems': Langellier, K. M. (1989). *Op. Cit. No. 73*. p.271.

## 2.5 The Paradox of Language

The paradox of language refers to the fact that all talk involves both *language use* and *language resource*.<sup>78</sup> As discussed in the previous section of this chapter, while an array of linguistic resources are flexibly utilised by speakers - in some cases in quite contradictory ways - research has exposed how 'regular patterns' can also be identified *across* accounts;<sup>79</sup> the range of linguistic resources with which actors fashion their descriptions and claims are not limitless. Gieryn highlights this limited repertoire available to scientists with regard to the boundary-work in their accounts:

the space for science is empty because, at the outset of boundary-work, nothing of its borders and territories is given or fixed by past practices and reconstructions in a deterministic way. But that idea could easily be exaggerated into a silly conclusion that every episode of boundary-work occurs *de novo*, and that there are no patterns at all from one episode to the next. Scientific practices and antecedent representations of it form a *repertoire* of characteristics available for selective attribution on later occasions. That repertoire is presumably not limitless; it might be extremely challenging these days to persuade others that eye of newt and toe of frog make witches purveyors of 'good laboratory practice'. Interpretative flexibility in the boundaries of science need not imply infinitely pliable.<sup>80</sup>

The very fact that discursive and rhetorical psychologists and constructivist writers on boundary-work acknowledge the limited character of linguistic resources available to speakers - the fact that some interpretative repertoires appear to achieve 'a provisional and contingent obduracy'<sup>81</sup> - highlights the essential collectivist dimension implicit within actors' talk.

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<sup>77</sup> See Billig, M. (1991). *Op. Cit. No. 72* and Fairclough, N. (1992). *Op. Cit. No. 66* for discussion of these respective terms.

<sup>78</sup> These are terms taken from the writing of Billig. Billig, M. (1991). *Op. Cit. No. 72*. And as Wetherell and Potter claim, 'discourse is manufactured out of pre-existing linguistic resources with properties of their own, much as a bridge is put together using guides, concrete and cable, some of which is flexible, some hard and so on': Wetherall, M. and Potter, J. (1988). *Op. Cit. No. 30*. p.171.

<sup>79</sup> McInlay, A. and Potter, J. (1987). *Op. Cit. No. 42*. p.445. Likewise Fairclough also highlights this point with the use of the term 'systematic variation'. Fairclough, N. (1992). *Op. Cit. No. 66*. p.68.

<sup>80</sup> Gieryn, T. (1995). *Op. Cit. No. 9*. pp.406-7.

<sup>81</sup> Gieryn, T. (1995). *Ibid.* p.407.

The rhetorical patterns evident across actors' stories are linked to the groupings of wider interpretative or speech communities.<sup>82</sup> In this sense, the analysis of discourse should involve two distinguishable yet intimately related tasks of study which mirror the fact that 'stories are implicated *within* as well as *distinct from* the occasion on which they are told'.<sup>83</sup> On the one hand, study should investigate the situational context of language use. This means unearthing and describing the rhetorical resources (systematic variation) and the contextual employment of these resources when speakers manufacture their accounts (flexibility and variation). On the other hand, it should move beyond linguistic and social psychological theory and also seek to contextualise the rhetorical resources employed by speakers within a wider framework of social structure; locating the particular construction of stories with reference to the broader social order. To deny or neglect either of these two tasks results in an under-developed explanation of the ideological dynamics of language.

Billig has outlined the conceptualisation of language use and resource in his rhetorical psychology, showing how it necessitates an appreciation of phenomena outwith the text. Employing the 'game' metaphor to describe language he puts it like this:

yet arguing...is more than strategic game-playing. There is a broader society, and its history of inequality which has provided the linguistic bats and balls for the players themselves. If this is forgotten, then the broader themes of the ideological critique will vanish from the theoretical horizon.<sup>84</sup>

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<sup>82</sup> Fairclough, N. (1992). *Op. Cit. No. 66*. p68. And also Langellier, K. M. (1989). *Op. Cit. No. 73*. He writes: 'from this perspective the personal narrative shifts from a *unit* of discourse...to a *type* of discourse among other types that comprise the talk of a culture': p.261. It is not here suggested that speech communities hold monopolies over rhetorical resources; the same discourse (interpretative repertoire) may be drawn upon by members of different communities, also the same discourses can in some cases be constructed in either negative or positive light (Parker, I. (1992b). *Op. Cit. No. 55*. Fairclough, N. (1992). *Op. Cit. No. 66*.

<sup>83</sup> Langellier, K. M. (1989). *Op. Cit. No. 73*. p.261.

<sup>84</sup> Billig, M. (1991). *Op. Cit. No. 72*. p.20.

A social orientation to language is built upon an attempt to bridge the macro-micro divide commonly identified and discussed within social theory.<sup>85</sup> Such an approach highlights how language construction is simultaneously a vehicle for human contingency and yet also exemplifies the structural limitations that shape individuals' lives.<sup>86</sup> Fairclough endorses this conceptualisation of language and the resulting style of analysis when he states:

analysis of discursive practice should, I believe, involve a combination of what one might call 'micro-analysis' and 'macro-analysis'. The former is the sort of analysis which conversation analysts excel at: the explication of precisely how participants produce and interpret texts on the basis of their members' resources. But this must be complemented with macro-analysis in order to know the nature of the members' resources...that is (sic.) being drawn upon in order to produce and interpret texts.<sup>87</sup>

It is not denied that people's tellings are rhetorically complex; they do contain much variation and, as discussed earlier, this is one useful tool for analysing the ideological function of accounts. However, the resources for discursive construction

<sup>85</sup> For a good discussion of micro-macro issue in sociology more generally see Knorr-Cetina, K. and Cicourel, A. (eds) (1981). *Op. Cit. No. 59*. This divide has represented a problem for sociology since the very formation of the modern discipline. It is also a feature that has been acknowledged in examining conventional and unconventional medical knowledge and beliefs. As Cant and Sharma claim with reference to their focus upon alternative and complementary medicines and the study of their knowledge, in practice studies should bridge the two levels of analysis. As they put it: 'Recent studies in the sociology of and anthropology of knowledge have tended to emphasise the linkages between what sociologists used to call the *micro* and *macro* levels of analysis. But the more general theorizing work has tended to privilege the macro, concentrating on achieving some kind of society that is emerging, and how it is different from that which has gone before. These are valid questions, but in answering them the insights derived from *studies of specific occupational groups and their workplaces, of the ways in which their knowledge is communicated among themselves and others...*sometimes seems to get lost' (my emphasis). Cant, S. and Sharma, U. (eds). (1996). *Complementary and Alternative Medicines: Knowledge in Practice*. London, Free Association. p.20. As the authors later suggest, work should direct attention upon both the *explicitly political* and the *more local processes* involved in the maintenance and transformation of medical knowledge.

<sup>86</sup> Billig has conceptualised this dualism when he defines the paradox of language. He claims, 'the use of language involves both autonomy and repetition. The speaker simultaneously is in charge of language and is captured by it'. Billig, M. (1991). *Op. Cit. No. 72*. p.8. In addition, Langellier, K. M. (1989). *Op. Cit. No. 73* also highlights this dualism with reference to personal narratives. 'In telling personal narratives participants are shaped by social constraints but they can also appropriate sedimented stories and refashion their meaning': p. 265. Likewise Wetherell and Potter explain how speakers' constructions involve an *active selection* out of many available linguistic resources: Wetherall, M. and Potter, J. (1988). *Op. Cit. No. 30*. p.171.

are not chosen at random and this can be seen in the way that members of the same cultural system of meaning draw upon 'a restricted number of linguistic repertoires when they are constructing appropriate accounts of actions and beliefs ... [and their] discourse will display regular patterns which can be seen to be systematically related to particular interpretative tasks'.<sup>88</sup> Textual analysis which restricts itself to the situational context of language use promotes a one-sided *individualistic* emphasis upon the rhetorical strategies of speakers.<sup>89</sup> It thus neglects the crucial recognition that 'the engagement with the world is (fundamentally) a collective engagement',<sup>90</sup> and therefore that an exploration of accounts requires an examination of the wider collectivities within which individuals are located.

Resolving the paradox of language requires an appreciation of the ways in which interpretative communities act to *co-ordinate* the rhetorical resources and actions of individual members<sup>91</sup> and an examination of the role particular stories may play in relation to these wider collective units. As Plummer proposes, we need to ask a range of related questions if we are to develop a sociology of story telling:

what are the links between stories and the wider social world - What brings people to give voice to a story at a particular historical moment? What are the different social world's *interpretative communities that enable stories to be told and heard in different ways?*<sup>92</sup>

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<sup>87</sup> Fairclough, N. (1992). *Op. Cit. No. 66*. p.85. In response to this claim Fairclough proposes that social analysts adopt what he calls a *multidimensional approach* to language, one which combines selected aspects of linguistic theory with social theory.

<sup>88</sup> McInlay, A. and Potter, J. (1987). *Op. Cit. No. 42*. pp.444-445.

<sup>89</sup> Fairclough, N. (1992). *Op. Cit. No. 66*. p.71.

<sup>90</sup> Bloor, D. (1996). 'What is a Social Construct?'. Unpublished paper presented at London School of Economics, All London History and Philosophy of Science meeting on 'The Role of Constructivism in Current Studies of Science', p.3. To highlight the equivalent notion in symbolic interactionism, 'Stories can be seen as joint actions. Everywhere we look in a human society we see people engaging in forms of joint action. People may be seen as engaged in fitting together lines of activity around stories; they are engaged in story actions'. Plummer, K. (1993). *Op. Cit. No. 4*. p.20.

<sup>91</sup> For discussion of this concept of co-ordination see Barnes, B. (1995). *The Elements of Social Theory*. London, UCL Press.

<sup>92</sup> Plummer, K. (1995). *Op. Cit. No. 4*. p.25. (my emphasis). Clifford also suggests that 'truths' as constructed within accounts 'are meaningful to specific interpretative communities in limiting historical circumstances': Clifford, J. (1988). *The Predicament of Culture: Twentieth Century Ethnography*,



In order to introduce this wider context of language we must bring back the ‘inferential nerve’<sup>93</sup> to an examination of discursive constructions. In order to avoid a position of idealism we must endorse some form of epistemic realism - a belief that ‘there is a world out there’<sup>94</sup> beyond texts. Plummer has outlined this point with a view to his development of a sociology of story telling. He claims:

this sociological approach...does not stay at the level of textual analysis: it insists that story production and consumption is an empirical social process involving a stream of joint actions in local contexts themselves bound into wider negotiated social worlds. Texts are connected to lives, actions, contexts and society. It is not a question of ‘hyperrealities’ and ‘simulacra’ but of practical activities, daily doings and contested truths’<sup>95</sup>

This position, which is adopted here, on the one hand highlights the partial and incomplete nature of all accounts and therefore represents a weak version of empiricism; while on the other hand it eschews the ‘naive’ realist assumption of traditional social science that language directly reflects reality. This approach still allows for an empirical investigation of social structure.<sup>96</sup>

To explain: from informants’ accounts the researcher can move beyond the situational context of the interview and empirically explore the constraints that

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*Literature and Art*. Cambridge, MA, Harvard University Press. Langellier, K. M. (1989). *Op. Cit. No. 73* makes a similar claim with reference to personal narrative: ‘story telling does not happen just between people but between social actors under particular constraints that exceed linguistic and interactional constraints. In other words, we ask not just how people manage to do personal narratives in conversation but what else are they doing as they tell a stories? How does storytelling function in the larger social context?’: p.261. Polyani, L. (1979). ‘So What’s the Point?’. *Semiotics* 25: 207-214, provides a similar yet slightly different conception of storytelling. She suggests that the point of stories - what is of interest within them - is culturally, socially and personally constrained: p.207.

<sup>93</sup> Halfpenny, P. (1988). ‘Talking of Talking, Writing of Writing: Some Reflections on Gilbert and Mulkay’s Discourse Analysis’. *Social Studies of Science* 18: 169-82.

<sup>94</sup> Plummer, K. (1995). *Op. Cit. No. 4*. p185.

<sup>95</sup> Plummer, K. (1995). *Ibid.* p.24. Parker makes similar appeals for study. He claims that, ‘in order to analyse institutions, power and ideology, we need to stop the slide into relativism. We need some sense of the real to anchor our understanding of the dynamics of discourse’: Parker, I. (1992b). *Op. Cit. No. 55*. p.22.

<sup>96</sup> As Plummer suggests, the specific empiricism of social world theory teaches us ‘that there is a world “out there” which constrains us and is open to exploitation and inspection. The world, in truth, is a hypothesis...empiricism harbours many positions, and for me should not be readily equated with positivism. Nevertheless, the fleeting but grand judge of human inquiry is the world of human activities, not disembodied philosophical speculation’. Plummer, K. (1995). *Op. Cit. No. 4*. p.185. For a similar



collectivities enforce upon GPs' discourse. It must be stressed that this approach does not signify a movement back to a traditional model of inquiry. What is essential is that the informants' accounts are not construed as reflecting and standing in for a direct examination of the GPs' social worlds. Ultimately, we have to infer such practices, interactions and how the social world of medicine operates (and, as will be seen in the next section, this is one important role for sociological theory). Individual lives are essentially unknowable<sup>97</sup> and the actual day-to-day practice of complementary therapies by these general practitioners (and in a broader sense the whole of their professional backstage culture) is *not* directly revealed from the interview material collected by this study. Instead, the talk of GPs reveals the patterned rhetorical constructions by which these GPs make sense, justify and legitimate their professional work to themselves and others<sup>98</sup> - it is this notion of patterning that sociologists refer

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criticism of 'hard forms of realism' see Giere, R. N. (1988). *Explaining Science: A Cognitive Approach*. Chicago, University of Chicago Press. p.6.

<sup>97</sup> Plummer, K. (1995). *Op. Cit. No. 4*. p.20.

<sup>98</sup> This patterning of discursive constructions can be either an unconscious or a more reflective process. In the majority of cases actors 'represent' their wider collective community through the unreflective 'naturalisation' of their constructions. In other words, their discursive constructions (more specifically the constraints upon their discursive constructions) go unnoticed by the storytellers; they perceive their story as the way it is. As Fairclough suggests with regard to discourse: 'It should not be assumed that people are aware of the ideological dimensions of their own practice. Ideologies built into conventions may be more or less naturalised and automatized, and people may find it difficult to comprehend that their normal practices could have specific ideological investments'. Fairclough, N. (1992). *Op. Cit. No. 66*. p.90. Bauman portrays a similar position with regard to group constraints more generally. He writes, 'In most cases, as a matter of fact, I am not aware that I possess all that knowledge (as directed by my group). If asked, for example, what the code is through which I communicate with other people and decipher the meaning of their actions towards me, I would, in all probability be taken aback: I probably would not quite understand what I had been asked to do, and when I did comprehend the question, I would not be able to explain the code.' Bauman, Z. (1990). *Thinking Sociologically*. Oxford, Blackwell. p.26. However, there may also be instances where language and particular constructions of talk (conveyed to another outside their world - such as a social science interviewer) illustrate these same resources through a more *reflective* process. As McInlay and Potter claim, actors may 'package' their criticisms and attacks upon other groups in different ways depending upon the circumstances in which they talk. For example, McInlay and Potter state what they see as a significant difference between the interview-based work of Gilbert and Mulkay and their own explorations of talk from a psychology conference. They write: '[Gilbert and Mulkay] used interviews with individual scientists in which the scientist was communicating only with the researcher and, in addition, was assured anonymity. In this situation, scientists can produce highly negative descriptions of others' behaviour without fear of comeback. In contrast, conferences are highly public arenas where talk is *designed* to be heard by scientist peers. This faces scientists who account for error with a problem. For if they produce a contingent version of other scientists' behaviour - citing incompetence or bias, say - this could be heard

to, often implicitly, when they write of 'culture' speaking through texts. As Potter *et al.* explain, 'the picture we gain from a text is not determined so much by some underlying experience of the actor but by the arrangement and structure of the words in the text and their place in general *cultural systems of meaning*'.<sup>99</sup> As such, it is through these stories that we can examine the rhetorics and boundaries of the particular cultural system of meaning to which these GPs belong.<sup>100</sup> What is obviously demanded here is a conceptual landscape which will fulfil two basic requirements. First, the thematic framework must provide effective tools with which to conceptualise interactionally important units of social organisation. Second, and related to this first requirement, the framework must be sufficiently sensitive to the flexible rhetorical constructions, formulations of territory and borders found within

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as an accusation and, as a consequence, perhaps involve the speaker in heated dispute': McInlay, A. and Potter, J. (1987). *Op. Cit. No. 42*. p.446. Following this suggestion we can assume that the interviews conducted in this study with GPs likewise provide a 'safe' environment in which interviewees can attack 'others'. Strauss also outlines a similar point with regard to such face-to-face interaction, 'Although there are only two main actors...there are also other actors who are visible only to the audience, or to one or the other...Thus, each...while acting toward the other, may also be acting toward an invisible third, much as if the latter were actually present. To make the matter more complicated, if actor A is officially representing a close group with respect to actor B then in a real sense the entire group should be there upon the stage, so that when A makes a commendable statement they will nod in collective appraisal, and then A will as much respond to them as to B'. Strauss, A. (1969). *Mirrors and Masks*. San Francisco, Sociology Press. pp.55-56. We can consider this point with reference to the GPs' accounts analysed in this thesis. To put the statement another way would be to ask: How did the GPs interpret my status (as outsider to their community) and the context of the interaction which made up the interview? I would claim it was clearly established from my initial contact letter and from the nature of my interest (which I explained fully before each interview) that they were presenting themselves to me as representatives of their wider professional community. As such, it is reasonable to assume that they may on occasion have anticipated the reaction of their colleagues and other members of their professional community in relation to their accounts and constructions. Furthermore, I would also add, with reference to Billig, M. (1991). *Op. Cit. No. 72*. that it is also conceivable that they reflect upon the claims and approach of therapists of other medicines in their rhetorical constructions and, in this sense, they may be more reflective about their own position as commonly perceived by other competing groups.

<sup>99</sup> Potter, J., Stringer, P. and Wetherell, M. (1984). *Social Texts and Context: Literature and Social Psychology*. London, Routledge and Kegan Paul, p.23 (my emphasis). Also see Parker, I. (1992b). *Op. Cit. No. 55*. He also highlights the point of relationalism. He claims, 'there may be no mirrors of nature in philosophy, science, psychology or literature, but there is a crucial sense in which the pictures in the texts which comprise these disciplines reflect one another within the dominant culture...as well as being relational, modern cultural systems of meaning can be understood as overarching knowledge structures meshed through with power'. Parker, I. (1992b). *Ibid.* p.47.

the accounts of members of such units. As the following sections of this chapter illustrate, this thesis adopts one conceptual landscape which meets these requirements.

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<sup>100</sup> It must not be forgotten that such rhetorical constructs and boundaries are not static but are constantly in flux, thus the snapshot referred to is one which is historically specific. In a very short

## 2.6 Social Worlds Theory

Social worlds theory provides a range of analytical tools with which ‘systems of meaning’ can be conceptualised and analytically explored. Moreover, as will be shown in the following section, a social world perspective is aptly suited to the detailed study of professional medical communities and as a consequence assists the social analyst in overcoming some of the difficulties associated with previous work in this field.<sup>101</sup> In addition, the perspective also harbours a number of assumptions which are in tune with the theoretical points developed so far in this chapter.<sup>102</sup> First, SWT is a *relationalist* perspective in that it ‘encourages us to seek out “perspectives” that are many and varied, but at the same time stresses the need for them to be related to each other in order to gain a wider picture’.<sup>103</sup> Closely linked to this relationalism is the influence of *pragmatism* which leads to an investigation not only of ‘perspectives’ but also of the practical consequences of holding them: groups compete for a purpose - namely to capture and influence the mode of representation and ultimately to claim

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space of time the world of general practice will have undoubtedly undergone further change.

<sup>101</sup> See chapter 1.6 for an outline of these problems as they relate to specific work within medical sociology which has examined unconventional medicines.

<sup>102</sup> While these points are introduced below, a more extensive outline of each is interwoven with a detailed discussion of SWT in the next section of this chapter. These features of SWT, and their affinity with the focus of some writers within constructionism, should not come as a surprise given the ‘constructionist’ influences upon the tradition of symbolic interactionism (the wider perspective from which SWT has developed). Here, I refer to the work of Mead and other pragmatist philosophers. Mead’s work in particular contains assumptions and underlying currents which are clearly the early foundations of those tenets to which later constructionists have turned.

<sup>103</sup> Plummer, K. (1995). *Op. Cit. No. 4*. p.185. Not only does this approach fit alongside that of Billig’s rhetorical psychology (as outlined earlier in this chapter) but also Abbott, A. (1988). *Op. Cit. No. 11*. and Gieryn, T. (1995). *op cit. no. 9*. add weight to this feature of a sociological approach to professions. Furthermore, Gieryn has employed the work of Abbott as a means of constructing his ecology or geography of professions. As Gieryn suggests of Abbott’s position, ‘Abbott rejects the idea that the development of a profession is independent of the practices and claims of *other* professions or differently organised occupations. Instead, the history of one profession is best understood through its contests with other professions for jurisdictional control over tasks - the professions together constitute a system that is the proper unit of analysis for sociological theorising. Abbott focuses on *interprofessional* competitions created when more than one occupational group lays claim to the legitimate provision of...tasks’: Gieryn, T. (1995). *Op. Cit. No. 9*. p.409.

and capture material resources.<sup>104</sup> Both of these features of SWT harmonise with the performative and argumentative approach to talk outlined earlier.<sup>105</sup> Third, in line with symbolic interactionism more generally, SWT also directs attention towards the micro-macro divide and likewise is concerned with bridging or fusing these two levels of analysis.

The next section of this chapter outlines a range of concepts which are central to a social worlds perspective. Through the introduction of a number of theoretical arguments taken from a selection of work outwith social worlds theory (work from within the sociology of scientific knowledge and the sociology of professions) some of these key concepts are further refined and developed. In addition, I wish to illustrate how the concern with discourse found in the literature outlined in previous sections of this chapter transplants into a social world perspective. As a result the emphasis within this thesis is upon social world members' rhetorical constructions.

The chapter then goes on to illustrate how these concepts can be employed to examine the area of medicine with particular reference to the practice of complementary medicine and its appropriation by sections of the medical community. As will be shown SWT comes into its own when asking questions about how medical communities co-ordinate the discursive boundaries and constructions of their members, and how these members make appeals and attack other groups with regard to medicine, medical roles and tasks. The outline of social worlds (in this case medical worlds) prior to analysis of GPs' accounts is not meant to substitute for the

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<sup>104</sup> Other writers outwith SWT have similarly concentrated upon exposing the ways rhetorical constructions may be used by community members as a means of capturing and dominating modes of representation. These writers have also highlighted how such competition is played out via the persuasion, coercion, and argumentation found in texts. See for example, Mehan, H. (1996). 'The Construction of an LD Student: A Case Study in the Politics of Representation'. In M. Silverstein, and G. Urban (eds). *Natural Histories of Discourse*. London, Chicago University Press.

characterisations of territory and the boundary demarcations of these social world members. Neither is it intended to provide clear and definitive boundaries between worlds. Instead, the notion of multiple social worlds is to be used as an analytical map which provides a starting point and which guides the analyst through social terrain which is in many ways a far more amorphous and messy reality.<sup>106</sup>

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<sup>105</sup> In particular the SWT notion of worlds competing within an arena can be comfortably combined with aspects of Billig's rhetorical psychology.

<sup>106</sup> Strauss explains: 'The social world perspective yields the usual interactionist vision of a universe often bafflingly amorphous. But the perspective has analytic thrust and implicit directives': Strauss, A. (1978). 'A Social World Perspective'. *Studies in Symbolic Interaction* 1: 199-228. p.123. Similarly, Clarke outlines how social world theory guides her investigation of reproductive science. As she states, 'All research is guided by an approach and a perspective - assumptions about how one can learn and know, the nature of causality, concepts of change, and the proper unit of analysis': Clarke, A. (1990). 'A Social Worlds Research Adventure'. In S. Cozzens and T. Gieryn (eds). *Theories of Science in Society*, Bloomington: Indiana University Press. Linked to this point writers have stressed the practical use of social world concepts in approaching empirical research. Gieryn writes, 'empirical embodiment of a "social world" is a function of researchers' interests and problems-at-hand', Gieryn, T. (1995). *Op. Cit. No. 9*. p.412. and Clarke proposes that the level of a world (in terms of how the analyst wishes to segment it) is also dependent upon the task at hand. She states, 'whether X is a world or a subworld depends upon one's analytical focus of the moment', Clarke, A. (1990). *Ibid.* p.22. Both social world analysts and Gieryn stress the fussiness of boundaries. Gieryn for example writes of how he, 'seeks to recover (boundaries') messiness, contentiousness, and practical significance in everyday life'. Gieryn, T. (1995). *Op. Cit. No. 9*. p.393. With regard to assembling a story about rhetoric and stories I follow Potter's line when he writes of his arguments with Collins' work: 'My version of Collins' work is a story put together for the purposes of this text, it is designed to make a particular argument. Collins, the empirical programme of relativism, philosophy of science - all these things are simplifying and clarifying categories that allow me to build a story. That is not to say that the story is wrong or untrue or inaccurate - for those judgements presuppose that there is a definitive "Collins", a definitive



### 2.6.1 Social Worlds and Legitimacy Processes

A community is a group of people with a shared past, with ways of recognising and displaying their differences from other groups, and expectations for a shared future. Their culture is the ways, the strategies they recognise and use and invent for making sense, from common sense to disputes, from telling to learning; it is also their way of making things and making use of them and the ways they make over the world.<sup>107</sup>

For some, the relation between professions and their work is simple. There is a map of tasks to be done and an isomorphic map of people doing them. Function is structure. But the reality is more complex; the tasks, the professions, and the links between them change continually.<sup>108</sup>

A social world is a cultural unit of meanings.<sup>109</sup> It represents a subuniverse or local system of symbolization within the wider symbolic universe commonly referred to as a culture.<sup>110</sup> Kling and Gerson define the 'cultural area' otherwise known as a social world as 'a set of common or joint activities or concerns, bound together by a network of communication';<sup>111</sup> and Clarke likewise suggests social worlds 'consist of individuals who share resources, activities, commitments and also build shared ideologies about how to go about their business'.<sup>112</sup>

Worlds develop around either a core activity or a set of core activities.<sup>113</sup>

Social worlds can be identified across many substantive areas<sup>114</sup> and exist in different

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philosophy, and so on that this account could be compared with. It is a story that works here': Potter, J. (1996). *Op. Cit. No. 15*. p.34.

<sup>107</sup> Traweek, S. (1992). *Op. Cit. No. 33*. p.438.

<sup>108</sup> Abbot, A. (1988). *Op. Cit. No. 11*. p.35.

<sup>109</sup> The concept of a social world has its origins in the early Chicago sociology of Park, Znaniecki and others in the first half of the twentieth century. While Shibutani first coined the term social world back in the 1950s the more contemporary works of Strauss and other symbolic interactionist followers have exposed the concept to a more systematic and thorough investigation both theoretically and empirically.

<sup>110</sup> For a detailed discussion of social worlds within the wider symbolic universe termed a culture see Strauss, A. (1993). *Continual Permutations of Action*. New York, Aldine de Gruyter. pp.155-157. Strauss likens living in a symbolic universe to goldfish in a bowl. He writes, 'To live in a symbolic universe is quite like the situation of several goldfish living in a customary bowl of water, the natives of both habitats being unaware of the limits of their respective worlds...While recognition of and some measure of distance from one's own symbolic universe are sometimes furthered by experiences with other people's, yet it is difficult to break out of the symbolic fishbowl': Strauss, A. (1993). *Ibid.* p.155.

<sup>111</sup> Kling, R. and Gerson, E. (1978). 'Patterns of Segmentation and Intersection in the Computing World'. *Symbolic Interaction* 2: 24-43.

<sup>112</sup> Clarke, A. (1990). *Op. Cit. No. 106*. p.131.

<sup>113</sup> Unruh introduces the term 'organisational foci' to define these features, encompassing 'various products, activities, experiences, life-styles, and technologies which are associated with that which



shapes and forms - they can be small or large in size, geographically expansive or congregated around specific locales, and while some establish complex hierarchies and institutional representative bodies others remain relatively simple in organisation.<sup>115</sup>

The social space in which a number of worlds congregate comprises an arena.<sup>116</sup> Within arenas worlds compete and negotiate over practices, technologies and other dimensions of core activities. Strauss has outlined how the processes of legitimation are prominent in all worlds and arenas. This concept refers to the continual assessment within and between worlds of the worth and acceptability of performance, product, technologies, and members. As Strauss suggests, these processes pertain to 'issues like what, how, when, where and who; that is, who can legitimately or properly do certain things, with certain means or materials, at appropriate places and times, and in certain acceptable ways?'<sup>117</sup> Legitimacy disputes

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brings social worlds together': Unruh, D. (1980). 'The Nature of Social Worlds'. *Pacific Sociological Review* 23(3): 271-296. p.283.

<sup>114</sup> For example social world researchers have employed the approach to investigate a wide range of substantive areas: the art world (Becker, H. (1974). 'Art as Collective Action'. *American Sociological Review* 39: 767-776. Becker, H. (1976). 'Art Worlds and Social Types'. *American Behavioural Scientist* 19: 703-719); the computing world (Kling, R. and Gerson, E. M. (1978). *Op. Cit. No. 110.*) and science (Gerson, E. M. (1983). 'Scientific Work and Social Worlds'. *Knowledge: Creation, Diffusion, Utilization* 4(3): 357-377) amongst many others.

<sup>115</sup> Indeed, as Clarke suggests one of the major features of SWT is that the framework highlights that worlds may be but are not necessarily synonymous to formal organisations and institutions. For discussion of SWT in relation to organisational theory more generally see Clarke, A. (1991). 'Social Worlds/Arenas Theory as Organisational Theory'. In D. Maines (ed.). *Social Organisation and Social Process: Essays in Honor of Anselm Strauss*. New York, Aldine de Gruyter.

<sup>116</sup> It must be noted that social world analysts such as Strauss and Clarke have developed a somewhat wide-ranging analytical framework for their empirical investigations. They stress the significance of other worlds beyond those traditionally recognised by sociology as within the remit of study. For example, highlighting the significance of identifying the role non-experts (patients) play with regard to the practice of medicine, Unruh has suggested a wide scope with his outline of four levels of social worlds ranging from local social worlds through to social world systems. See Unruh, D. R. (1980). *Op. Cit. No. 113*. Strauss has further supported this approach with the introduction of the broader concept of *matrix* which stretches beyond and incorporates the analytical unit labelled an arena. See Strauss, A. (1993). *Op. Cit. No. 110*. Chapter 11. As will be explained later in this chapter this thesis sets itself a more limited scope due to the interest and focus of the study. In short, investigation is limited to the professional worlds of medical practitioners and the arena built around healing and medical practices.

<sup>117</sup> Strauss, A. (1982). 'Social Worlds and Legitimation Processes'. *Studies in Symbolic Interaction* 4: 171-190. p.173.

not only relate to the worth and acceptability of activities and who can do them but also, more significantly, involve contests over the definition and representation of whole realms of reality. Gieryn outlines this point when he describes ‘credibility contests’ - a term which is synonymous to legitimacy disputes as explained in SWT - and how they involve attempts to determine ‘epistemic authority’. He explains:

‘Credibility contests’ are a chronic feature of the social scene: bearers of discrepant truths push their wares wrapped in assertions of objectivity, efficacy, precision, reliability, authenticity, predictability, sincerity, desirability, tradition. People often take shortcuts when faced with practical decisions about how to allocate ‘epistemic authority’, the legitimate power to define, describe, and explain bounded domains of reality.<sup>118</sup>

Legitimation processes also occur beyond and between worlds; the practices, technologies and knowledge of competing worlds are delegitimated and deauthenticated (at least in comparison to those sets of activities and products which the assessing world is itself associated with).<sup>119</sup> The concept of legitimacy claims has close links to some analytical features developed within other sociological traditions and schools.<sup>120</sup> In particular, it is useful to examine Gieryn’s notion of ‘boundary-work’ to help further explain and understand legitimacy processes.<sup>121</sup> Legitimacy and boundary construction are complementary features of the same claims-making activities within worlds. To explain, when medical world members make claims as to what and who is authentic within their world they automatically engage in boundary

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<sup>118</sup> Gieryn, T. (1999). *Cultural Boundaries of Science*. London, Chicago University Press. p.1.

<sup>119</sup> As Strauss writes, ‘the defining of different types of activities, and the building of organisations for furthering them, is often accompanied by a growing conviction that “what we are doing” is not just as legitimate but even more legitimate than those of another [world]’: Strauss, A. (1982). *Op. Cit. No. 117*. p.175.

<sup>120</sup> Here I refer to both Gieryn’s work on boundary construction of scientists - see Gieryn, T. (1995). *Op. Cit. No. 9* - and Abbott’s outline of the concept of jurisdictional claims and contests. Abbott, A. (1988). *Op. Cit. No. 11*.

<sup>121</sup> For an outline of boundary-work see Gieryn, T. (1983). ‘Boundary-Work in the Professional Ideologies of Scientists’. *American Sociological Review* 48: 781-795. Gieryn, T. (1995). *Op. Cit. No. 9*. Gieryn, T. (1999). *Op. Cit. No. 118*. For a slightly different approach to this concept see Fisher, D.

construction; for instance, they construct boundaries between medicine and non-medicine, between those classified as authentic medical practitioners and those who are not.

One crucial feature embedded in the social world focus upon legitimacy contests and debates relates to the notion of power and to the empirical investigation of a material reality beyond texts. In short, worlds enter legitimacy disputes in an attempt to maintain or to gain *resources* as a means of supporting and enhancing production and activities. Indeed, building upon some of the pragmatist philosophy of Mead, SWT suggests that while rhetorics are crucial features of worlds they must also be accompanied by an examination of ‘more palpable matters’<sup>122</sup> including material resources. This concern redirects - more precisely, augments - the approach to ideology as found within discursive and rhetorical psychology. While these latter perspectives rightly conceptualise all talk as having an ideological dimension, SWT, in line with its pragmatist roots, draws attention to the practical consequences of particular discursive constructions for wider social groupings. The performative nature of language as outlined by the new paradigm psychologists, is stretched further afield; language can be said to be performative in that social world members’ constructions are geared towards the acquisition or maintenance of material resources and power.<sup>123</sup>

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(1990). ‘Boundary Work and Science’. In S. E. Cozzens and T. F. Gieryn (eds). *Theories of Science in Society*. Bloomington, Indiana University Press.

<sup>122</sup> Strauss, A. (1978). *Op. Cit. No. 106*.

<sup>123</sup> As Clarke proclaims, ‘the analyst needs to elucidate which worlds and subworlds come together in a particular arena and why, what their perspectives are, and *what they hope to achieve through collective action*’ (my emphasis). Clarke, A. (1991). *Op. Cit. No. 115*. p.128.

## 2.6.2 The Maintenance Mechanisms of Social Worlds: Self-Referential Speech Communities

As can be inferred from the discussion above, central to the concept of a social world is the notion of communication.<sup>124</sup> An exploration of this point can provide the link between some of the elements of constructionist work focusing upon language use and a social world perspective. Social worlds are collective interpretative units.<sup>125</sup> This point illuminates the parallels between the approach to language embodied within both a social world perspective and the discursive analytical approaches from within constructionism. Just as constructionism informs us that talk and stories are not unproblematic reflections of reality but necessarily involve interpretation, so SWT is founded upon the claim that as languaged beings our 'interaction is...interpretative; assigning meaning to objects, events, scenes, settings or contexts, and relationships'.<sup>126</sup> In effect, social worlds provide the *contextual codes* for interpretation and action; they are networks of meaning or, to put it another way, 'world views' which 'unite social actors in terms of practices, procedures, and perspectives'.<sup>127</sup>

Plummer has taken the notion of communication a step further with particular regard to the wider units of interpretative communities in his elaboration of a

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<sup>124</sup> Indeed, writers within the social world perspective often refer to Mead's notion of 'universe of discourse' as an aid to defining and explaining social worlds. For use of this term see Mead, G. H. (1932). *The Philosophy of the Present*. Chicago, Chicago University Press. Unruh has emphasised the importance of communication to the conceptualisation of a social world when he writes, 'since the boundaries of social worlds are not necessarily territorial or geographical, communication centres are vital to co-ordinate activities, production, and interrelationships among those involved', Unruh, D. (1980). *Op. Cit. No. 113*. p.284. In addition, Shibutani (who interestingly first coined the term social world) suggests the boundaries of social worlds 'are set...by the limits of effective communication', Shibutani, T. (1955). 'Reference Groups as Perspectives'. *American Journal of Sociology* 60: 562-69. p.566.

<sup>125</sup> This feature is not surprising given the fact that SWT was developed, at least in part, in response to criticism that symbolic interactionism neglected the study of macro-structures. See Maines, D. R. (1979). 'Social Organisation and Social Structure in Symbolic Interactionist Thought'. In A. Inkeles (ed.). *Annual Review of Sociology* vol. 3. Palo Alto, CA, Annual Review.

<sup>126</sup> Strauss, A. (1993). *Op. Cit. No. 9*. p.151.

sociology of stories.<sup>128</sup> He conceives of stories as symbolic interaction thereby stressing the central role stories play within social worlds. As Plummer explains:

We are constantly writing the story of the world around us: its periods and places, its purposes and programmes, its people and plots. We invent identities for ourselves and others and locate ourselves in these imagined maps. We create communities of concern and arenas of activity where we can make our religions, tend to our 'families', practise our politics, get on with our work...And everywhere we go, we are charged with telling stories and making meaning - giving sense to ourselves and the world around us.<sup>129</sup>

While only adopting particular elements of Plummer's general sociology<sup>130</sup> his work nevertheless helps guide the approach to social worlds as developed in this study. Following Plummer's lead we can explore two interrelated lines of investigation. First, we can examine the 'social work [stories] perform in cultures'<sup>131</sup> (thereby positioning them more forcefully and prominently within the wider social order). Second, we can also analyse the role of social worlds in the production of stories (both telling and listening): in order to understand how and why stories get told and also how they are consumed by others we need to consider the contextual conditions (interpretative communities) in and through which stories are maintained and facilitated.

A similar line of enquiry has been promoted by Gieryn.<sup>132</sup> Gieryn suggests that the very content of professionals' accounts of their practice territory and boundaries is variable and flexible, and that such features provide the cultural authority of

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<sup>127</sup> Unruh, D. (1980). *Op. Cit. No. 113*. p.272.

<sup>128</sup> See Plummer, K. (1995). *Op. Cit. No. 4*. It must be noted that Plummer does develop his sociology of stories with particular reference to the personal narratives of the intimate. However as he himself suggests, 'this book is about the proliferation of personal narratives of the intimate in the late twentieth century. *But the ideas in this book could be applied to any story telling process: the focus on sexuality is merely one instance. This chapter is hence concerned with laying out some of the contours of a sociology of stories with wider applicability than just the intimate*': Plummer, K. (1995). *Ibid.* p.19.

<sup>129</sup> Plummer, K. (1995). *Ibid.* p.20.

<sup>130</sup> For example I part company with Plummer's emphasis upon such features as the tropes of talk and how stories are plotted through space and time.

<sup>131</sup> Plummer, K. (1995). *Ibid.* p.19.



professional communities. If we translate this approach into the framework of SWT it means that we redirect attention towards stories within worlds to reveal not only the processes of distancing, legitimation and authentication but also the tactics with which these processes are conducted. This means stretching the interest of a social world perspective beyond that originally conceived by Strauss.<sup>133</sup>

As explained earlier, one feature of the legitimacy processes of social worlds relates to *internal mechanisms* whereby members' practices and interactions and thereby the status of the member him/herself are assessed. This point alerts us to the processes by which social worlds are maintained. Social worlds are sustained through the day-to-day interactions of individual members who effectively act on behalf of worlds as representatives.<sup>134</sup> Through these interactions members of a social world are

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<sup>132</sup> Gieryn, T. (1983). *Op. Cit. No. 121*.

<sup>133</sup> The concern with the details of the tactics involved in particular processes is not only neglected by Strauss but more significantly rejected in his original blueprint for SWT. Strauss's rejection of this level of analysis can be seen when he writes with regard to distancing strategies, 'It is the distancing process, rather than the specific tactics, which is important phenomena'. Strauss, A. (1982). *Op. Cit. No. 117*. p.176.

<sup>134</sup> Shibutani, whose work heavily influenced the SWT of Strauss, defines social worlds as, 'universes of regularised response built up by people in interaction with one another', Shibutani, T. (1955). *Op. Cit. No. 124*. p.565.

Here it must be noted that there are different categories of membership in worlds. See Garrety, K. (1997). 'Social Worlds, Actor-Networks and Controversy: The Case of Cholesterol, Dietary Fat and Heart Disease'. *Social Studies of Science* 27: 727-773. As Unruh outlines there are insiders, regulars, tourists, and strangers, who are all in different ways members of social worlds. See Unruh, D. (1979). 'Characteristics and Types of Participation in Social Worlds'. *Symbolic Interaction* 2(2): 115-130, and Unruh, D. (1980). *Op. Cit. No. 113*. pp.280-282 for details of these categories. I acknowledge that such categorisations may provide a useful analytical tool for exploring certain aspects and features of worlds. For example, with regard to medicine, this type of development encourages an analysis beyond the scope of simply medical worlds (as defined by traditional sociological approaches) to include non-expert participation, etc. However employing these categorisations of Unruh I would suggest that this thesis concentrates exclusively upon the rhetorical presentations of regulars/insiders. It may be that tourists for example who may briefly pass through or engage with a particular medical world evoke less stringent and decisive 'sanctions' and policing'; these tourists may be more difficult to survey and sanction and in addition their presence may be of less concern to insider/regular members. This does not, I would argue, weaken the importance of the concept of self-reference for understanding worlds, not least for understanding the 'core' regular membership of worlds made up of members who 'have a significant degree of commitment to their social world through good times and bad', Unruh, D. (1980). *Op. Cit. No. 113*. p.282. Unruh himself has pinpointed this feature of sanctions relating to core members when he writes of voluntary identification of members with a world. As he qualifies, 'while departure or withdrawal from social worlds retains a certain "voluntariness", economic, political and interpersonal commitments may be built up so that departure is painful or deleterious'. Unruh, D. (1980). *Ibid.* p.277.

repeatedly judged by their co-members as to their authenticity and appropriateness within the community, and, ultimately, are kept in line through the continual threat or actual mobilisation of censorship. Strauss, the founder of SWT, explains how social worlds are sustained via the process of censorship through interaction when he writes:

Each divergent act or product has the potential of being censured because it lacks priority, beauty, or other important values. If engaged in or produced by a reputable member, then his worldly soul is still redeemable - perhaps he was out of sorts, or showing lapse of judgement, or ill, or just joking "or something." But people who step out of bounds too frequently will either be considered mavericks and disregarded...or may become candidates for informal or formal excommunication.<sup>135</sup>

At this point in the discussion I would like to momentarily turn to some work from within the sociology and philosophy of science as a means of augmenting the notion of a social world and a conceptualisation of how worlds are maintained. While couched in different terminology, the concept of a social world from within SWT holds some similarities to the notion of paradigms - a notion formulated within Kuhn's philosophy of science<sup>136</sup> and further built upon by sociologists of scientific knowledge.

Kuhn's community-based model of scientific paradigms illustrates the centrality of the community and practice of professionals in co-ordinating their approach. A paradigm is 'a whole way of thinking and working which filters what members are likely to find acceptable or unacceptable in new work or other traditions'.<sup>137</sup> This represents one significant point of overlap between a Kuhnian

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<sup>135</sup> Strauss, A. (1982). *Op. Cit. No. 117*. p.188.

<sup>136</sup> Kuhn, T. (1962). *The Structure of Scientific Revolutions*. Chicago, University of Chicago. It must be noted that Kuhn's concept of paradigm is somewhat ambiguous and has been the centre of controversy. Kuhn himself used the word in a number of different ways. As Masterman claims there are up to twenty-one different ways in which Kuhn uses the term. Masterman, M. (1970). 'The Nature of a Paradigm'. In I. Lakatos, and A. Musgrave (eds). *Criticism and the Growth of Knowledge*. London, Cambridge University Press.

<sup>137</sup> A definition taken from Cant, S. and Sharma, U. (eds) (1996). *Op. Cit. No. 84*. p.9.



approach and a social worlds approach to professional communities; both the concept of a social world and that of a paradigm refer to systems or networks of meaning or interpretation and, furthermore, both *imply* the centrality of 'practice' to understanding how these systems are sustained.<sup>138</sup>

However, in order to exploit the full potential of Kuhn's position in helping expand and explain the concept of a social world we need to explore more recent work within the sociology of scientific knowledge which has drawn upon Kuhn's path-breaking perspective. In particular, the work of Bloor which has drawn upon both Kuhn's notion of paradigms and Wittgenstein's concept of language-games<sup>139</sup> as a means of exploring the scientific community and practice represents a useful supplement to the social world approach. Bloor's work is founded upon a model of 'self-reference'<sup>140</sup> and this model can be used as a means of understanding social

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<sup>138</sup> To qualify, Kuhn's original philosophical work points towards practice as a central concept within paradigms, yet arguably, as will be explained a little later in this section, his work neglects a proper sociological orientation and requires further refinement for the full implications of 'practice' to become evident in his approach. See Bloor, D. (1983). *Wittgenstein: A Social Theory of Knowledge*. London, Macmillan. p.142.

<sup>139</sup> Wittgenstein's notion of language-games harmonises with the constructionist perspective and social world approach to professional communities. As Wittgenstein himself claims with regard to language-games: 'what has to be accepted, the given, is - so one could say - *forms of life*': Wittgenstein, L. (1922). *Philosophical Investigations II*. London, Routledge and Kegan Paul. p.xi. Lyotard from within postmodern sociology has also drawn upon Wittgenstein's notion of language games as a means of understanding discourse. See Lyotard, J.-F. (1984). *The Postmodern Condition: A Report on Knowledge*. Minnesota, University of Minnesota.

<sup>140</sup> For an excellent outline of self-reference and the self-fulfilling prophecy of social life see, Barnes, B. (1983). 'Social Life as Bootstrapped Induction'. *Sociology* 17: 524-45. This notion of self-reference also relates closely to the notion of sanctioning which holds many similarities to Gieryn's notion of 'expulsion'. Both concepts (sanctioning and expulsion) refer to the processes by which 'deviants' are sanctioned and the professional community policed. Gieryn describes expulsion as: 'efforts to expel not-real members from their midst. The labels attached by insider scientists to those booted out vary: deviant, pseudoscientist, amateur, fake. Those excluded typically give off the appearance of being "real" scientists, and may believe themselves to be so. But insiders define them as poseurs illegitimately exploiting the authority that belongs only to bona fide occupants of the cultural space for science. Such processes of social control no doubt foster a homogeneity of belief and practice within science by threatening insiders with banishment for perceived departures from the norm': Gieryn, T. (1995). *Op. Cit. No. 9*. p.432. Gieryn writes of 'expulsion' as a form of boundary-work among scientists. While this notion is less central to his work, Gieryn nonetheless would appear to be writing about self-reference as a means of policing the scientific community. Gieryn writes, 'A common kind of boundary-work involves insider's efforts to expel not-real members from their midst. The label attached by insider scientists to those booted out vary: deviant, pseudoscientist, amateur, fake. Those excluded typically give off the appearance of being "real" scientists, and may believe themselves to be so. But insiders

worlds. Self-reference refers to the mechanisms which are involved in sustaining

‘standards’ within a particular speech community. As Bloor describes:

in order to provide an account of standards which are impersonal, rather than merely subjective dispositions, we can bring in interaction between different concept users. They create a standard which is external to each individual by their citing it, appealing to it, and criticising each other in the name of the standard.<sup>141</sup>

As this quote suggests these mechanisms of ‘self-reference’ can be seen as synonymous with the processes of authenticity explained in Strauss’s work;<sup>142</sup> both encourage conceptualisations of internal validity which place onus upon interaction between community members. To employ the terminology of SWT: the *authenticity*

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define them as poseurs illegitimately exploiting the authority that belongs only to bona fide occupants of the cultural space for science. *Such processes of social control no doubt foster a homogeneity of belief and practice within science by threatening insiders with banishment for perceived departures from the norm*: Gieryn, T. (1995). *Op. Cit. No. 9*. p.432. Also see Zuckerman, H. (1977). ‘Deviant Behaviour and Social Control in Science’. In E. Sagarin (ed.). *Deviance and Social Change*. Beverly Hills, CA, Sage. Barnes’ work complements this position. Barnes explains how sanctioning maintains concept application in a community when he writes: ‘Most of the time individuals apply classifications without hesitation, confident that their designations are correct and will be verified as correct by fellow members of their community. And, for the most part, such designations are so verified. Suppose, however, that two individuals in a community were to differ over what they took to be a routine act of concept application. For the first, a creature was obviously and indubitably a dog; for the second, it was a cat. No amount of discussion altered matters...Consider now the question of which of the two individuals had correctly labelled the creature. There is no absolute criterion available here. However, if in their particular community, all other competent members happened to agree with the ascription ‘dog’, then that would be, as far as they were concerned, the correct ascription; and their communal behaviour would doubtless reflect this shared judgement’: Barnes, B. (1983). ‘On the Conventional Character of Knowledge and Cognition’. In K. D. Knorr-Cetina and M. Mulkay (eds). *Science Observed*. London, Sage. pp.31-32.

<sup>141</sup> Bloor, D. (1996a). *Op. Cit. No. 90*. p.3. Also see Bloor, D. (1996b). ‘Idealism and the Sociology of Knowledge’. *Social Studies of Science* 26: 839-856. As Bloor claims in this work, ‘consensus is sustained in the course of interaction, where the interaction is one in which the consensus itself features in the way in which the interaction is understood by its participants. The consensus operates by reference to its normative character - that is, it is created and exists through its use as a standard for commentary and sanction. Deviation is thus understood in terms of being ‘wrong’, not merely of being ‘unusual’’. p.848.

<sup>142</sup> This similarity can be seen clearly when Bloor writes about membership of groups. He suggests, ‘at the most basic level, we can say that someone is a member of a group if, and only if, they are treated as members. In the simplest cases, being regarded as a member of a group is a necessary and sufficient condition for being a member. In general, somebody who nobody regards as a member, isn’t a member’: Bloor, D. (1996b). *Op. Cit. No. 141*. p.842. Here we can quite easily substitute the word membership for authenticity and it is reasonable to suggest both Bloor and Strauss are writing of the same phenomena with reference to group life.

of a medical world is not decided in isolation from, or separate from, the practices which constitute the core activities of that world.<sup>143</sup>

### 2.6.3 Understanding and Investigating Change within Social Worlds

Now, having some of these important characteristics of social worlds in place, there is a need to qualify and revise a further feature of these worlds. The outline of social worlds so far raises a dilemma for the medical sociologist. The argument at this point tends to suggest a number of related characteristics of social worlds: first, with its emphasis upon conventions as guiding classification and interpretation, this perspective seems to imply a *deterministic* vision of social world practices with members' behaviour prescribed by cultural conventions.<sup>144</sup> Second, associated with this determinism, worlds are characterised as homogenous communities; consensus is assumed across the same parent culture of meaning.<sup>145</sup> Furthermore, this stress upon

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<sup>143</sup> The similarity with Bloor's position is revealed when he writes, 'I want to emphasise that these self-referring processes are not external to the moment-by-moment use of the paradigm as a model and a resource...the mechanisms of self-reference are not external to the content of scientific practice but are...constitutive of it'. Bloor (1996a). *Op. Cit. No. 90*. p.4.

<sup>144</sup> Bloor, Barnes and Henry make this point in relation to 'the conventional character of classification and the need to understand convention as a collective accomplishment. This idea can give rise to difficulties. The notion that classifications are conventions is widely accepted, as a result of our experience with alternative ways of classifying the world, all manifestly sensible and satisfactory. But we tend to think of the associated problems simply as those of choosing conventions. We imagine that once they are chosen they will then *determine* our subsequent taxonomic activity. It is as if the world is a cake, ready to be cut in any number of ways, indifferent to how it is actually sliced.' Bloor, D., Barnes, B. and Henry, J. (1996). *Scientific Knowledge: A Sociological Analysis*. London, University of Chicago Press. p.55. As Bloor writes, 'Rationalist critics of Kuhn sometimes ask how, on his account, scientific revolutions are possible at all. If a group is committed to an existing paradigm, why don't they elaborate and defend it forever?'. Bloor, D. (1983). *Op. Cit. No. 139*. p.142. Likewise, a parallel problem can be seen within social representational theory in psychology. While this approach suggests representations are the outcome of unceasing babble and a permanent dialogue between individuals, these representations are also echoed and complemented elsewhere. See Moscovici, S. (1984). 'The Myth of the Lonely Paradigm: A Rejoinder'. *Social Research* 51: 939-67. As Billig suggests this does not allow for radical change within groups and he stresses, 'echoing and complementing may have their place in the unceasing babble, but the babble would not be a babble if dialogue were based purely on repetition and agreement. Just as unceasingly are the sounds of argumentation and negation to be heard'. Billig, M. (1991). *Op. Cit. No. 72*. p.74.

<sup>145</sup> The Kuhnian approach of paradigms neglects concern with intersection and segmentation within paradigms. As Gerson suggests, 'Kuhn's theory pays little attention to the mechanisms that trigger such revolutions [of paradigms] and the processes that shape them and lead to eventual success or failure', Gerson, E. M. (1983). *Op. Cit. No. 114*. p.371.

consensus leads to an under-conceptualisation of change. At this stage in the discussion no effective analytical tools have been proposed to examine and understand these processes of change. However, in order to overcome these problems we can draw upon other concepts from within SWT and other related traditions. The analytical landscape of SWT is far more rich than has so far been suggested and the perspective provides a number of analytic tools with which to investigate *change* within professional communities.<sup>146</sup>

#### 2.6.3.1 Anti-Determinism

Action is shaped by conditions but in turn is shaped by active actors. Thus, one can say yes, there definitely is social structure, but it is not immutable, totally unshapable, and certainly not entirely determining of action.<sup>147</sup>

One feature of a social world perspective which helps move beyond a conceptualisation of worlds as closed and static relates to the anti-determinism of symbolic interactionist sociology and pragmatist philosophy more generally. In line with the paradox of discourse explained earlier, social worlds theory also stresses the agency of actors, ‘emphasising the creative potential of individuals and groups acting in the face of social limitations’.<sup>148</sup> As Plummer explains, ‘isolated individuals and abstracted societies are there none. We human beings are social world makers, though we do not make our social worlds in conditions of our own choosing’.<sup>149</sup> Strauss has provided a detailed explanation of how constraints and contingency are at one and the same time constitutive of interaction. He explains this in terms of a triadic

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<sup>146</sup> Here I follow Gerson who has made this assertion with regard to the social study of science. Gerson writes with regard to the complex processes of intersection and segmentation within and between scientific worlds: ‘I suggest that no analytical approach to science studies other than the social worlds approach...is capable of describing and analysing this pattern of changes’. Gerson, E. M. (1983). *Ibid.* p.371.

<sup>147</sup> Strauss, A. (1993). *Op. Cit. No. 110*. p.247.

conceptualisation of symbolisations manifest within particular worlds. Social world members carry ‘products of previous symbolising’<sup>150</sup> into new interactions (this represents established structure and acts as conditions for ongoing interaction);<sup>151</sup> symbolisation also occurs in the interaction itself; and furthermore, as a result potentially new symbolisations are produced from this new interaction, *ad infinitum*. In other words, ‘symbolisation gets confirmed, reaffirmed, maintained - as well as previously created or born - through interaction’.<sup>152</sup> Bloor, Barnes and Henry make the same point with their outline of a *finitist* account of classification. This concept refers to the open-endedness and revisability of future acts of classification within a speech community. As they themselves explain:

from a sociological perspective the importance of this key theme of finitism is that it reminds us of the status of every act of classification as a separate and problematic empirical phenomenon... We have put our knife into the cake and cut a certain way. But *nothing determines* how we should continue to cut: we do not have to cut in a straight line. And indeed there is nothing to stop us pulling back the knife some way and starting again.<sup>153</sup>

This point mirrors the emphasis upon language resource and use (or to use the associated vocabulary of Billig, the stress upon repetition and autonomy) which underpins the conception of the dualist nature of language, and which similarly deconstructs the micro/macro distinction so commonly featured in sociological theory.<sup>154</sup> What this theme illustrates is that we should be careful to qualify the

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<sup>148</sup> Strauss, A. (1978). *Op. Cit. No. 106*. p.120. Also see Bloor, D. (1996b). *Op. Cit. No. 141*. p.850.

<sup>149</sup> Plummer, K. (1995). *Op. Cit. No. 4*. p.20.

<sup>150</sup> Strauss, A. (1993). *Op. Cit. No. 110*. p.152.

<sup>151</sup> As Strauss himself claims, ‘when sociologists write about social structure or culture as entering into or affecting interaction, they surely mean this kind of symbolising, at least implicitly’. Strauss, A. (1993). *Ibid*.

<sup>152</sup> Strauss, A. (1993). *ibid*. Bloor has made a similar claim. He writes, ‘this is the sense in which meaning is indeterminate, so the collective work involved in monitoring concept application is never completed’: Bloor, D. (1996b). *Op. Cit. No. 141*. p.852.

<sup>153</sup> Bloor, D., Barnes, B. and Henry, J. (1996). *Op. Cit. No. 144*. p.55.

<sup>154</sup> As Strauss suggests analysis should not be ‘restricted to ‘micro’ or ‘macro’ studies of groups or their processes’. Strauss, A. (1978). *Op. Cit. No. 106*. p.121.



relationship between worlds and their representative members: worlds do not *determine* members' behaviour; more specifically, while worlds *inform, constrain* and *co-ordinate* their members' actions<sup>155</sup> it is the case that 'meanings [born and facilitated within worlds] are endlessly problematic *in principle*'.<sup>156</sup>

### 2.6.3.2 Segmentation and Subworlds

The *anti-determinist* character of SWT directs the social investigator to the *processual change* within worlds.<sup>157</sup> In order to move toward a more systematic examination of such change we can utilise the concepts of segmentation and subworlds from within a social world perspective.

Segmentation alerts us to the continual evolution of *specialization* experienced within worlds;<sup>158</sup> at different times certain social world members become interested in

<sup>155</sup> Unruh has stressed this antideterminism in SWT when he writes, 'Without assuming a deterministic stance towards social life, it would appear that it is possible to ferret out some of the social, political, and economic conditions which influence, free, or constrain the involvement of social actors in the social worlds studied'. Unruh, D. R. (1980). *Op. Cit. No. 113*. p.292.

<sup>156</sup> Bloor, D. (1996b). *Op. Cit. No. 141*. p.852. Faberman has also highlighted a similar point with regard to symbolic interactionism more generally. He terms this position 'soft determinism'. Faberman, H. (1991). 'Symbolic Interaction and Postmodernism: Close Encounters of a Dubious Kind'. *Symbolic Interaction* 13: 471-88, p.481.

<sup>157</sup> Strauss identifies this focus as the influence of Mead's pragmatist philosophy. Strauss terms this Meadian 'fluidity'. Strauss, A. (1978). *Op. Cit. No. 106*. p.121. Strauss explains the centrality of a study of processes when he writes, 'While I am not overlooking the possibility that processes can be discovered independent of a focus on social worlds, the social world perspective makes processual study virtually mandatory'. Strauss, A. (1978). *Ibid.* p.126; Plummer also explains the importance of change to a social world approach. He claims, 'and the meanings we invoke and the worlds we craft mesh and flow, but remain emergent: never fixed, always indeterminate, ceaselessly contested. Change is ubiquitous: we are always becoming, never arriving; and the social order heaves as a vast negotiated web of dialogue and conversation'. Plummer, K. (1995). *Op. Cit. No. 4*. p20. Bucher, R. (1962). 'Pathology: A Study of Social Movements Within a Profession'. *Social Problems*, 10(1): 40-51. Bucher also highlights the focus upon change which is at the heart of SWT and its application to the examination of professional communities. He writes of the aim 'to develop a theoretical framework which would focus more pointedly upon diversity and change in occupations, and provide some initial formulations of the main processes involved'. p.40.

<sup>158</sup> See Gerson, E. M. (1983). *Op. Cit. No. 114*. p.360-361. In addition Kling and Gerson describe segmentation as 'the pervasive tendency for worlds to develop specialised concerns and interests within the larger community of common activities, which act to differentiate some members of worlds from others': Kling and Gerson (1978) *op. cit. no. 111*. p.32. Once again the approach from within SSK of Bloor, Barnes and Henry complements this focus. These authors likewise stress the boundary construction not just between science and non-science but also between disciplines and specialisms

and form alliances and networks with colleagues around a distinct and new set of activities.<sup>159</sup> Provided a sufficient number of world members participate and actively support these activities a new subworld may evolve within the larger parent world. Of course, the trajectory and lifespan of potential subworlds varies greatly. While some evolve extensively over time with networks and territory eventually becoming established groupings within the wider social world, others experience only a brief flicker of life - they may be consumed by larger more established subworlds or vanish altogether as quickly as they first arrived.

So, the inclusion of segmentation and subworlds in the social world approach provides a conceptual imagery 'of groups emerging within social worlds, evolving, developing, splintering, disintegrating, or pulling themselves together, or parts of them falling away and perhaps coalescing with segments of other groups to form new groups, often in opposition to older ones'.<sup>160</sup> Thus, unlike Kuhn's approach to paradigms, SWT stresses the heterogeneity and contestation within worlds; the authentic character of a world and its members are issues which are constantly negotiated, debated and fought about within the ranks of the world itself in the form of subworld alliances.

### 2.6.3.3 Intersection, Appropriation and Authentication

Both anti-determinism and segmentation help the social analyst conceptualise flux and change associated with social worlds. However, so far the discussion has been restricted only to internal change *within* worlds. Meanwhile, research has

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within the scientific community. See Bloor, D., Barnes, B. and Henry, J. (1996). *Op. Cit. No. 144*. p.140.

<sup>159</sup> Unruh describes the segmentation within worlds thus: 'the social world's capacity to redefine, spontaneously negotiate, and splinter the focus'. Unruh, D. (1980). *Op. Cit. No. 113*. p.283.

<sup>160</sup> Strauss, A. (1982). *Op. Cit. No. 117*. p.172.



repeatedly illustrated the overlap between worlds and how members from different scientific and other professional communities frequently interact and co-operate with each other as a means of accomplishing everyday practice.<sup>161</sup> Consequently the social analyst requires the conceptual apparatus which will enable an investigation and understanding of these contacts between worlds. SWT, with its stress upon intersection, provides the effective conceptual tools for meeting this requirement.

Intersection is one possible consequence of segmentation processes within worlds.<sup>162</sup> As explained earlier, subworlds are continually born, develop and extend and as a result of these processes worlds often trespass within and/or co-habit the cultural space of another world. Intersection, as examined within SWT to date, has usually been directed towards areas of co-operation and collaboration between worlds.<sup>163</sup> In order, to expand the scope of the concept of intersection I would like to

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<sup>161</sup> Star, S. L. and Griesemer, J. R. (1989). 'Institutional Ecology, "Translations" and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology, 1907-1939'. *Social Studies of Science* 19: 387-420. Clarke, A. (1990). *Op. Cit. No. 106*. Fujimura, J. H. (1988). 'The Molecular Biological Bandwagon in Cancer Research: Where Social Worlds Meet'. *Social Problems* 35: 261-283. Fujimura, J. H. (1992). 'Crafting Science: Standardized Packages, Boundary Objects and "Translation"'. In A. Pickering (ed.). *Science as Practice and Culture*. Chicago, University of Chicago Press.

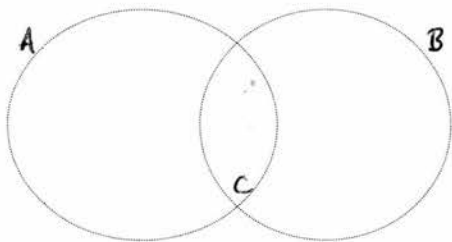
<sup>162</sup> Strauss explains how intersection can be interrelated to segmentation when he writes, 'some of the contributing conditions pertain to the evolution of technology, to differentiated experiences within the world, to the evolution of new generations of members, to the recruitment of new kinds of members, and to the impinging of other worlds...segmenting leads to the intersecting of specifiable subworlds. Intersecting, in other words, occurs usually not between global worlds but between segments'. Strauss, A. (1978). *Op. Cit. No. 106*. p.123.

<sup>163</sup> As Gieryn writes of SWT (in specific relation to Abbott's work in the sociology of professions): 'starting from the observation that science is the intersection of multiple social worlds, they turn away from Abbott's interest in the jurisdictional competition engendered by such contact and instead examine how the co-operative pursuit of tasks is accomplished in spite of boundaries that could prevent separated social worlds from achieving ends collectively'. Gieryn, T. (1995). *Op. Cit. No. 9*. p.412. The following quote from Gerson helps illustrate this point further. Gerson writes of intersection: 'an intersection consists of a system of negotiating contexts, in which resources flow between social worlds...These contexts are, in the case of intersections between social worlds, relatively long-term, containing repeated negotiations, and usually multiple in nature, taking place among many different participants in the social worlds involved'. Gerson, E. M. (1983). *Op. Cit. No. 114*. p.363. (my emphasis). As will be seen very shortly in this section this outline of intersection fits comfortably within the model that I have termed strong intersection. In addition, a number of other social world studies have concentrated upon collaboration and co-operation between worlds, see Star, S. L. and Griesemer, J. R. (1989). *Op. Cit. No. 161*. Clarke, A. (1990). *Op. Cit. No. 105*. Fujimura, J. H. (1988). *Op. Cit. No. 161*. Löwy, I. (1992). 'The Strength of Loose Concepts - Boundary Concepts, Federative Experimental Strategies and Disciplinary Growth: The Case of Immunology'. *History of Science* 30(4): 371-396.

develop a notion referred to but not given in-depth attention by Strauss: *degrees of intersection*.<sup>164</sup>

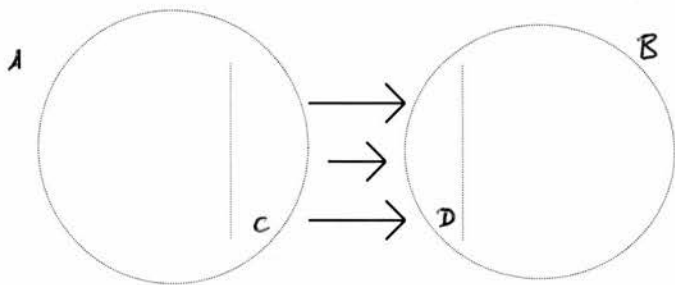
It is useful to conceive of two general models of intersection (see diagrams 1 and 2 below for schematic outline of these models).

**Diagram 1. Strong Intersection Between Worlds**



Parent world A and parent world B intersect in area C. This area is where members from both worlds may share working practices and practice space in collaborative work.

**Diagram 2. Weak Intersection Between Worlds**



A part of parent world B (the subworld D) is here adopting certain aspects of parent world A (as found in subworld C). As the arrows suggest adoption and

<sup>164</sup> Strauss, A. (1993). *Op. Cit. No. 110*. p.217.

translation is strictly one-way; while members of subworld D adopt features from subworld C they nonetheless remain fully outside the parent world A.

In some cases (and this is the model which has been focused upon by many social world researchers to date) there is *Strong Intersection* (see Diagram 1 above). This is where some world members not only adopt such things as the technologies and practices of another world but also establish close contact with its members and maybe even share working practices and practice space with them (see Area C in Diagram 1 above). Indeed, in extreme cases this collaboration may lead to what Gerson defines ‘mutual re-expression’. This is when ‘lines of work that trace to both “parent” lines form rapidly and tend to define problem areas for themselves that are at least partially outside the boundaries of both parent traditions’;<sup>165</sup> the collaboration between the participating members (from the different worlds involved) is so strong that they become located outside their respective social worlds and forge a ‘new’ identity beyond their original world boundaries.

In other cases, however, there may occur *Weak Intersection*. This is where certain activities of another world are adopted, but little or no contact is encouraged between respective members (see Diagram 2 above). In these cases the two or more sets of members from different social worlds continue to practise in isolation from each other while the legitimacy and credibility contests rage on; artefacts from another world are translated across world boundaries but no members accompany this movement. In cases of weak intersection, distancing and demarcation strategies between competing worlds are usually much more prominent and exaggerated than in circumstances of strong intersection. This point links to the processes of

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<sup>165</sup> Gerson, E. M. (1983). *Op. Cit. No. 114*. p.365.

*appropriation*, another concept which is alluded to yet has not received in-depth attention from within SWT and which is developed further here.<sup>166</sup>

Appropriation is the process through which social world members *translate* (and thereby make their own) 'foreign' practices, styles and technologies. Linked to appropriation is the process of authentication. Authentication refers to members' attempts to justify and legitimate their newly acquired activities, often in response to criticism from more 'traditional' world members who oppose such adoption. In short, authentication is the process through which the seizure and translation of 'exotic' aspects of other worlds is accomplished by entrepreneurial world members.<sup>167</sup> Strauss outlines how such 'entrepreneurial' subgroups face opposition from within their world when he writes:

Concerted criticism will come from established positions by proponents using ordinary unquestioned canons of truth, morality, beauty, usefulness, and propriety. From those ideational positions they will decry, debunk, seek to discredit, even get in-world or governmental rulings to squash the disclaimed new core activities. This opposition is not purely verbal, for it deals also in the materials stuff of the social world, that is, with resources - money, space, equipment, access to clients and so on. In consequence, the aspiring [subworld] will need to forge its own ideological weapons.<sup>168</sup>

Moreover, while 'new' objects are often adopted by social world members as a self-contained or ready made 'package' (this relates not only to technologies and

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<sup>166</sup> We can turn to the work of both Strauss and Abbott for assistance in exploring this concept; while neither has provided an in-depth examination of appropriation (in fact neither has labelled it as such) each has provided a preliminary sketch of this process. Abbott, A. (1988). *Op. Cit. No. 11*. Strauss, A. (1982). *Op. Cit. No. 117*. In addition, it can also be added that the notion of appropriation builds upon but also quite clearly extends beyond the focus of Potter's analysis of offensive and defensive rhetorical accomplishments, see Potter, J. (1996). *Op. Cit. No. 15*. p.107-8.

<sup>167</sup> This concept of entrepreneurs within worlds is taken from Becker, H. (1963). *Outsiders: Studies in the Sociology of Deviance*, New York, Free Press.

<sup>168</sup> Strauss, A. (1982). *Op. Cit. No. 117*. p.177. In terms of scientific work and worlds Gerson highlights the same problem facing the integration of 'new' practices and products: 'an entire line of work may find itself fighting for its life. The emergence of a new segment or intersection, with its associated revision of the "established" problem structure of a tradition, always raises the question: "Is this new way really part of our work? Is it really x-ology?" Such questions are the essence of issues of problem legitimacy. They may rise in response to the "importation" of new methods from another discipline or

instruments but also theoretical products and research findings) there is however a 're-expression' of the essence, the location or the worth of these packages in terms of the new world habitat.<sup>169</sup>

Reorienting our focus slightly we can interpret the authentication process as an attempt to deal with opposing tensions generated through importing 'external' activities. As Strauss describes it:

there is a pull toward being distinct from neighbouring [subworlds], but not so distinct as to be defined as outsiders altogether...This situation is complicated by the frequency with which defectors from one [subworld] will associate visibly with genuine outsiders, and adopt some of the latter's styles and technologies and activities; so much so that they can be accused of leaving the parent [social world] altogether - despite their claims that they have merely incorporated vital fresh ideas and techniques.<sup>170</sup>

Interpreted in terms of these opposing tensions, and also by building upon some of the work of Abbott and Strauss, the concept of authentication can be refined into two distinct yet highly intertwined strategic models. First, there is the need for the emergent subworld members to impute *affiliation* with the current activities of their wider social world. Abbott has presented two particular types of strategy with which such affiliation may be accomplished: *reduction*, where subworld members attempt to illustrate how a new activity is the same as other tasks already established within their wider social world;<sup>171</sup> and *metaphor*, where the activity is presented as 'like' other tasks already undertaken.<sup>172</sup> Secondly, with these claims of affiliation are *distancing*

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to the growth of interest in phenomena traditionally ignored by a discipline'. Gerson, E. M. (1983). *Op. Cit. No. 114*. p.367.

<sup>169</sup> See Gerson, E. M. (1983). *Ibid.* p.365 for discussion of the term 're-expression'.

<sup>170</sup> Strauss, A. (1982). *Op. Cit. No. 117*. pp.128-30.

<sup>171</sup> Gerson has also delineated this model of reduction. He writes, '...in cases of reduction...an entire area is shown to be "no more than a special case of" another - that is, there is nothing contained in the original perspective that was not contained, at least implicitly, in the re-expressed one'. Gerson, E. M. (1983). *Op. Cit. No. 114*. p.365.

<sup>172</sup> See Abbott, A. (1988). *Op. Cit. No. 11*. For reduction see p.36; 62; 98. And for metaphor see p.87. Furthermore, Gieryn has also provided a brief sketch of these strategies and has incorporated this area

*strategies*. These are the attempts by members to demarcate the newly acquired product or activity from that found in the social world from which it originated. Here, the features of legitimacy contests (such as attacking other worlds with the accusation of impropriety, lack of quality, etc.) and boundary constructions are paramount and thereby brought into sharper relief.

Having briefly sketched some of the key concepts of a social worlds perspective it is now possible to apply this framework more specifically to the case study of direct integrative practice.

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of Abbott's work into his constructivist work on boundaries. See Gieryn, T. (1995). *Op. Cit. No. 9*. p.410.

## 2.7 Application: The Case Study of Integrative Practice

### 2.7.1 The Conventional Medical World and General Practice

Social scientists have repeatedly shown how medicine can be conceptualised as a 'world view' - a way of thinking and interpreting the world which requires extensive socialisation.<sup>173</sup> In line with this work, we can conceive of conventional medicine as a parent medical world. This is a world which has established a highly developed hierarchical and organisational structure, with *core* membership being strictly constrained via qualifications and training, and good formal representation maintained through the British Medical Association.

However, as SWT alerts us, we must be sensitive to the segmentation processes and the subworlds within such parent worlds. The conventional medical world is not homogenous and subsequently its internal affairs are not characterised by tranquil and placid 'discussion'.<sup>174</sup> As commentators have suggested the medical profession is a 'broad church'.<sup>175</sup> Parssinen helps to point this out:

the medical profession is not a community with well-defined boundaries. Rather it is a community whose values and norms are constantly in flux; indeed, at any given time, the profession may encompass several distinct and

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<sup>173</sup> From within medical anthropology Good provides a description of medicine in this way: see Good, B. (1994). *Medicine, Rationality and Experience. An Anthropological Perspective*. Cambridge, Cambridge University Press. Similarly, Foucault conceptualises medicine as a discursive practice which represents, as Cant and Sharma explain, 'a way of carving up the world, looking at it and talking about it': Cant, S. and Sharma, U. (eds) (1996). *Op. Cit. No. 85*. pp.10-11. See Foucault, M. (1975). *The Birth of the Clinic: An Archaeology of Medical Perception*. New York, Vintage Books. Also see Atkinson, P. (1981). *Op. Cit. No. 26*. In this text Atkinson illustrates the construction and reconstruction of medical reality with regard to the teaching hospital. For an interesting yet now somewhat outdated review of such issues and literature see Atkinson, P. (1983). 'The Reproduction of the Professional Community'. In R. Dingwall and P. Lewis (eds). *The Sociology of Professions*. London, Macmillan.

<sup>174</sup> Abbott, A. (1988). *Op. Cit. No. 11*. p.115. Bucher, R. and Strauss, A. (1961). 'Professions in Process'. *American Journal of Sociology* 66: 325-340. Bucher, R. (1970). 'Social Process and Power in a Medical School'. In M. N. Zald (ed.). *Power In Organisations*. Nashville, Vanderbilt University Press. Another metaphor which has been used to look at health care and occupational groupings therein has been tribalism. This has been an interesting metaphor for understanding boundary conflicts and changes in the health field. For an outline of this metaphor see, Beattie, A. (1995). 'War and Peace Among the Health Tribes'. In K. Soothill, L. Mackay, and C. Webb (eds). *Interprofessional Relations in Health Care*. London, Edward Arnold.

<sup>175</sup> Cant, S. and Sharma, U. (eds) (1996). *Op. Cit. No. 85*. p.41.



possibly competing groups who are trying to define community standards quite differently.<sup>176</sup>

Employing the analytical tools of SWT we can dissect the conventional medical world into subworlds based on specialisms.<sup>177</sup> General practice can be seen to epitomise one such particular subworld; the professional world of general practice has developed its own core activities, ideologies, knowledge claims and styles of medical work from within the wider medical community. For example, there have been numerous attempts to expand the role and identity of this branch of the profession beyond a strictly biomedical model of illness by presenting general practice as 'whole person' medicine,<sup>178</sup> and the case for generalist practice and knowledge to be ascribed specialist status has also been made.<sup>179</sup> The subworld of general practice has developed its own representative body in the form of the Royal College of General Practitioners and has its own professional journals and networks.

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<sup>176</sup> Parssinen, T. M. (1979). *Op. Cit. No. 16*. p.105. Also see Salmon, J. W. (1984). 'Introduction'. In J. W. Salmon (ed.). *Op. Cit. No. 18*. As Salmon puts it, 'In actuality, the conceptual framework utilised by modern medicine is highly complex and contains many paradigms. This further complicates attempts to understand modern medicine as a social institution'. p.5. Hugman also identifies the contested nature of health care professions. See Hugman, R. (1995). 'Contested Territory and Community Services: Interprofessional Boundaries in Health and Social Care'. In Soothill, A., Mackay, L. and Webb, C. (eds). *Interprofessional Relations in Health Care*. London, Edward Arnold. p.32.

<sup>177</sup> A demarcation which is similar to that proposed by Mackay, L., Soothill, A. and Webb, C. (1995). 'Troubled Times: The Context for Interprofessional Collaboration'. In Soothill, A., Mackay, L. and Webb, C. (eds). *Interprofessional Relations in Health Care*. London, Edward Arnold.

As Hunter *et al.* suggest the education of doctors and the distinct Royal Colleges which represent sections of the profession further solidify these vertical relationships of hierarchy. See Hunter, D. J., McKeganey, N. P. and MacPherson, I. A. (1988). *Care of the Elderly: Policy and Practice*. Aberdeen, Aberdeen University Press.

<sup>178</sup> Armstrong, D. (1979). 'The Emancipation of Biographical Medicine'. *Social Science and Medicine* 13a: 1-8. Calnan, M. and Gabe, J. (1991). 'Recent Developments in General Practice: A Sociological Analysis'. In J. Gabe, M. Calnan and M. Bury (eds). *The Sociology of the Health Service*. London, Routledge. Bowling, A. (1981). *Delegation in General Practice*. London, Tavistock. Jefferys, M. and Sachs, H. (1983). *Rethinking General Practice*. London, Tavistock. Cant, S. and Sharma, U. (eds) (1996). *Op. Cit. No. 85*. p.2.

<sup>179</sup> Stacey, M. (1988). *The Sociology of Health and Healing*. London, Hyman. It must be noted that this subworld of general practice can be dissected further. There are competing groups within the ranks of general practice promoting a multiplicity of perspectives with regard to the issues of role, responsibilities and identity. General practice, like any other professional community, is to be seen as a contested world housing many different 'professional movements' (Bucher, R. (1962). *Op. Cit. No. 157*.) and issues of authenticity are constantly negotiated, debated and fought about within the ranks of the profession.

## 2.7.2 Unconventional Medical Worlds

Unconventional medicines have often been presented in stark opposition to the parent world of orthodox medicine. At the risk of oversimplification, writers - from within social science, the medical profession and the ranks of non-medically trained therapists alike - have suggested that unconventional therapies provide contrasting constructions of a range of medical topics such as aetiology, diagnosis, treatment, illness and disease categories, and the therapeutic relationship and responsibility to those found within conventional medicine.<sup>180</sup> While there may have been attempts by

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<sup>180</sup> Vickers for example claims 'one of the most interesting, and controversial, aspects of the complementary therapies is that they often involve ideas which diverge from conventional scientific understanding': see Vickers, A. (1993). *Complementary Medicine and Disability*. London, Chapman and Hill. p.5. Also see Aakster, C. W. (1986). *Op. Cit. No. 18*. BMA (1993). *Complementary Medicine: New Approaches to Good Practice*. Oxford, Oxford University Press. Douglas, M. (1994). 'The Construction of the Physician: A Cultural Approach to Medical Fashions'. In S. Budd and U. Sharma (eds). *The Healing Bond: The Patient-Practitioner Relationship and Therapeutic Responsibility*. London, Routledge. Peters, D. (1994). 'Sharing Responsibility for Patient Care'. In S. Budd and U. Sharma (eds). *Ibid*. Pietroni, P. C. (1992). 'Beyond the Boundaries: Relationship Between General Practice and Complementary Medicine'. *British Medical Journal* 305: 564-566. Sharma, U. (1994). 'The Equation of Responsibility: Complementary Practitioners and their Patients'. In S. Budd and U. Sharma (eds). *Ibid*. Spence, S. (1990). 'Meaning in Medicine: Tao of Healing?'. *Holistic Medicine* 5: 81-86. Taylor, R. C. (1984). 'Alternative Medicine and the Medical Encounter in Britain and the United States'. In J. W. Salmon (ed.). *Op. Cit. No. 18*. Berliner, H. S. (1984). 'Scientific Medicine Since Flexner'. In J. W. Salmon (ed.). *Op. Cit. No. 18*. Caplan, A. L., Engelhardt, H. T. and McCartney, J. J. (1981). *Concepts of Health and Disease - Interdisciplinary Perspectives*. London, Addison-Wesley. Sallerberg, A. (1991). "'Hawks" in Swedish Medical Care: A Study of Alternative Therapists'. *Research in the Sociology of Health Care* 9: 191-205. Featherstone, C. and Forsyth, L. (1997). *Medical Marriage*. Forres, Scotland, Findhorn Press. Also see Reason, P. *et al.* (1992). 'Towards a Clinical Framework for Collaboration Between General and Complementary Practitioners'. *Journal of the Royal Society of Medicine* 85: 161-164. They write, 'any multidisciplinary team involving general and complementary practitioners needs to work very hard in the initial stages to agree and understand the different models and assumptions its members bring to the joint exercise'. p.162. Linked to this characterisation, some social scientists have introduced Kuhn's notion of paradigms to conceptualise conventional and unconventional medicines in contrasting terms. See McKee, J. (1988). 'Holistic Health and the Critique of Western Medicine'. *Social Science and Medicine* 26(8): 775-784. Wolpe, P. R. (1990). 'The Holistic Heresy: Strategies of Ideological Challenge in the Medical Profession'. *Social Science and Medicine* 31(8): 913-923. Whitelegg, M. (1996). 'The Comfrey Controversy'. In S. Cant and U. Sharma (eds). *Op. Cit. No. 85*. Vickers, A. (1996). 'Research Paradigms in Mainstream and Complementary Medicine'. In E. Ernst (ed.). *Complementary Medicine: An Objective Appraisal*. Oxford, Butterworth, Heineman. What is also of interest regarding this Kuhnian approach and complementary medicine is the way that this social science perspective has been employed by practitioners and advocates of unconventional medicine as a means of defending their position and/or attacking the attitude of the medical profession. For an overview of this point see Cant, S. and Sharma, U. (eds) (1996). *Op. Cit. No. 84*. pp.9-10. And for evidence of this feature see Graham, H. (1990). *Time, Energy and the Psychology of Healing*. London, Jessica Kingsley. MacEoin, D.

some to align their 'modes of representation' to those of other worlds (for example, in their quest for professional recognition and status some within the ranks of the unconventional medical world have attempted to align their medical knowledge to that of medical science and thus employ some similar rhetorical constructions and claims to legitimate their practices)<sup>181</sup> more predominantly, the languages and practices of conventional and unconventional medicine reveal the use of different 'modes of thought',<sup>182</sup> the use of differing clinical models<sup>183</sup> and, in turn, contrasting ideas about and styles of doing medical work.<sup>184</sup>

While building upon these interpretations we must be cautious not to adopt them uncritically. Following the perspective of these earlier writers requires, quite rightly, defining and locating unconventional therapies in relational terms, i.e. as other and separate from conventional medicine. However, this approach, if not qualified, can lead to an oversimplified interpretation of the field and a failure to acknowledge some of the distinct features of individual therapies. Complementary therapies are less structurally bound than those subworlds which make up the medical community.

While some formal organisations have attempted to consolidate cross-therapy

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(1990). 'The Myth of Clinical Trials'. *Journal of Alternative and Complementary Medicine* 8(8): 15-18. In addition, some leading medical complementary practitioners have also employed Kuhn's notion of paradigms as a means of demarcating a biomedical from a holistic approach to primary care. See Leckridge, B. (1997). *Homeopathy in Primary Care*. London, Churchill Livingstone.

<sup>181</sup> Cant, S. and Sharma, U. (eds) (1996). *Op. Cit. No. 85*.

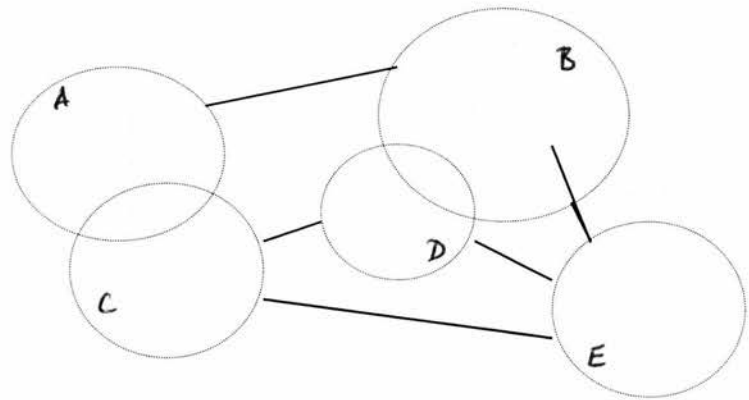
<sup>182</sup> Pietroni, P. C. (1992). *Op. Cit. No. 180*. We can also employ the language of Strauss; 'symbolic frames of reference' or 'symbolic canopy'. See Strauss, A. (1993). *Op. Cit. No. 110*. p.159.

<sup>183</sup> This has been best illustrated by writers involved in multidisciplinary primary care teams integrating complementary therapies alongside general practice. These writers have outlined the difficulties of bringing together different clinical models for collaborative practice. As Reason *et al.* write, 'there is a specialist diagnosis from the perspective of the practitioner's chosen discipline, made with the authority of their expertise: the biomedic may diagnose in terms of disease entity, the osteopaths in terms of body structure, the acupuncturist in terms of energy, and so on. Each practice has a unique perspective on the problems, elicits a different set of signs and symptoms, and has its own particular way of investigating and understanding them'. Reason, P. *et al.* (1992). *Op. Cit. No. 180*. p.162.

<sup>184</sup> It must not be forgotten, as Abbott explains, that such classification systems as diagnosis and treatment are prone to change. See Abbott, A. (1988). *Op. Cit. No. 11*. pp.40-48. This is a theme that will become more explicit a little later in this section.

concerns and stance<sup>185</sup> - these are attempts to present a strong and unified parent medical world to others - there is often little commonality and collaboration between the different therapies.<sup>186</sup> The therapies often have different underlying philosophies, origins and historical relations to the medical orthodoxy,<sup>187</sup> and research has illustrated some of the differences among non-medically qualified therapists in the way they present their role and identity.<sup>188</sup> Seen in this light, complementary medicines (taken together) do not represent a parent medical world but can be interpreted as a multiple of separate yet in some cases heavily overlapping medical worlds. (See diagram 3 below for schematic outline of these worlds and their relations to each other).

**Diagram 3. Locating Unconventional Medical Worlds**



To translate these insights to this case study, unconventional therapies - strictly in relation to the conventional medical world - represent medical worlds of strangers.

<sup>185</sup> For example the Council for Complementary and Alternative Medicine (CCAM) which was launched in 1985 and the National Consultative Council for Alternative Therapies (NCCAT) founded in 1989.

<sup>186</sup> Fulder, S. J. and Monro, R. (1982). *The Status of Complementary Medicine in the United Kingdom*. London, Threshold Foundation.

<sup>187</sup> Salmon, J. W. (ed.) (1984). *Op. Cit. No. 18*. p.8. Cant and Sharma have illuminated this point and in response have used the titles complementary and alternative medicines in the plural. See Cant, S. and Sharma, U. (eds) (1996). *Op. Cit. No. 85*.

<sup>188</sup> See Cant, S. and Calnan, M. (1991). 'On the Margins of the Medical Marketplace? An Exploratory Study of Alternative Practitioners' Perceptions'. *Sociology of Health and Illness* 13(1): 39-57.

Moreover, they are worlds of medical practice with practices and technologies which the world of general practice and the conventional medical world more generally are orientated to and confront. While complementary therapists and complementary medical worlds are characterised by their marginality and detachment from the conventional medical world, 'their activities, [do however], provide points of reference and comparison' for the general practice community.<sup>189</sup>

### **2.7.3 Intersection between General Practice and Unconventional Therapies**

As chapter one illustrates there have been numerous developments which have helped encourage and in some cases establish sites of intersection between general practice and complementary therapies. Drawing upon the SWT concepts explained earlier in this chapter, this section provides an analytical interpretation of these points of overlap. There are circumstances where strong intersection is occurring between selected complementary therapies and the world of general practice such as those projects where the primary care team is extended to include unconventional therapists.<sup>190</sup> In these cases members from both worlds co-operate and collaborate to provide patient care and, despite possible reluctance on both sides, share ideas and work styles. However this thesis concerns itself with a classic example of weak intersection; the practice of complementary therapies by GPs themselves within their traditional clinical space necessitates no collaboration or co-operation between the conventional medical world and the members of unconventional medical worlds.

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<sup>189</sup> Unruh, D. (1980). *Op. Cit. No. 113*. p.281.

<sup>190</sup> See Featherstone, C. and Forsyth, L. (1997). *Op. Cit. No. 180*. Pietroni, P. C. (1992). *Op. Cit. No. 180*. Reason, P. *et al.* (1992). *Op. Cit. No. 180*. Budd, C., Fischer, B., Parrinder, D. and Price, L. (1990). 'A Model of Co-operation Between Complementary and Allopathic Medicine in a Primary Care Setting'. *British Journal of General Practice* 40: 376-378. Paterson, C. and Peacock, W. (1995). 'Complementary Practitioners as Part of the Primary Health Care Team'. *British Journal of General Practice* 45: 235-258.



An emerging subworld has become established within general practice around the core activity of direct integrative practice. In recent years this subworld has established organisational representation such as the British Medical Acupuncture Society and the Faculty of Homeopathy which have undoubtedly developed local grass-roots networks or channels for communication between world members. While many practitioners may be involved in the subworld which has developed around integrative practice (i.e. those engaged in referrals or simply interested in or supportive of these practices but not actively engaged with them)<sup>191</sup> focus is here upon the insiders and regulars within this world: GPs practising unconventional therapies in their NHS surgeries. Unconventional therapies are still controversial within general practice<sup>192</sup> (direct integrative practice is yet to establish itself as a core activity within the profession). Furthermore, while there has been a rise in the number of practitioners personally practising therapies, this group still constitutes only a small fraction of the total number of GPs in Britain.<sup>193</sup> As a consequence, these regular subworld members still face opposition from more 'traditional' general practitioner world members. This point reminds us that general practice too, just like the larger medical world in which

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<sup>191</sup> These 'other' subworld members who are referring for example can be classified as 'tourists'. They have peripheral locations and loosely bound connections to the world. As such they may not face the same degree of sanctioning and policing as insiders/regulars. For further details of types of participation in worlds see Unruh, D. (1979). *Op. Cit. No. 134*.

<sup>192</sup> Spence, S. (1990). *Op. Cit. No. 180*. Editorial (Anon.) (1994). 'Fraternizing with Fringe Medicine'. *British Journal of General Practice* 44: 242-244. Visser, G. and Peters, L. (1990). 'Alternative Medicine and General Practitioners in the Netherlands: Towards Acceptance and Integration'. *Family Practitioner* 7: 227-232.

<sup>193</sup> As Saks writes of medical acupuncturists, 'the number of practising medical acupuncturists in contemporary Britain only represents a tiny fraction of the total complement of doctors in this country'. Saks, M. (1992b). 'The Paradox of Incorporation: Acupuncture and the Medical Profession in Modern Britain'. In Saks, M. (ed.). *Alternative Medicine in Britain*. London, Clarendon Press. p.188. Sharma highlights a similar point with regard to unconventional therapies more generally: 'whether patients can obtain non-orthodox treatment from a general practitioner under the NHS depends entirely on whether they happen to be registered with one of those few GPs who not only know something about non-orthodox medicine but who actually offer it to patients on a regular basis'. Sharma, U. (1992). *Complementary Medicine Today: Practitioners and Patients*. London, Routledge. p.94.



it is situated, is a contested world housing many different 'professional movements',<sup>194</sup> and that the authenticity of practitioners and activities are issues which are constantly negotiated, debated and fought about within the ranks of the profession.

When we focus our attention upon direct integrative practice within the general practice community we can identify clear examples of policing and explicit instances of sanctioning. The institutional organisation of general practice (and the medical community more generally) has in previous times exemplified the formal sanctioning by traditionalist world members.<sup>195</sup>

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<sup>194</sup> Bucher, R. (1962). *Op. Cit. No. 157*. Melia also writes of 'segments' within the nursing profession which promote their own versions of the nature of nursing. See Melia, K. M. (1987). *Learning and Working: The Occupational Socialization of Nurses*. London, Tavistock.

<sup>195</sup> For a good discussion of this point see Dew, K. (1997). 'Limits on the Utilization of Alternative Therapies by Doctors in New Zealand: A Problem of Boundary Maintenance'. *Australian Journal of Social Issues* 32(2): 181-197. Beattie has also explained one way in which health provider groups ('tribes') may sanction the particular redrawing of world boundaries. He writes, 'Individuals and official bodies who remain loyal to the traditional tribal boundaries will join together and seek common cause to oppose the redrawing of boundaries. For instance, referees for research proposals or research papers are often themselves likely to be firmly located within traditional discipline boundaries; course validation procedures may be linked to traditional professional bodies. Thus, certain projects may be approved because they fit with traditional 'tribe' interests, while other projects (those that challenge the dominant boundaries) may be disapproved of, being castigated and rubbished as disruptive or "unrealistic"'. Beattie, A. (1995). *Op. Cit. No. 174*. p.18. Similarly, Kilcoyne and Pietroni also evoke the imagery of tribes to conceptualise health professions and they too suggest sanctioning and policing is evident. They write, 'each profession acts in a sense like a tribe. Members are nurtured in distinctive ways, they develop their concepts in exclusive gatherings (called professional training, or college membership), they have their own leaders and pecking orders. Like all tribal societies they impose sanctions on non-conforming members. If a member takes on board the reality constructs of another

## 2.8 Important Features of the Analytical Landscape

In terms of providing an analytical landscape for dealing with the particular case study at hand and with issues of professional community and practice more generally, the thematic framework developed in this chapter incorporates a number of helpful features. These features overcome some of the shortcomings in previous work in this field (see chapter one for details).

First the theoretical framework outlined in this chapter moves away from a monolithic view of the medical profession towards an appreciation of the diversity and smaller competing groups within this community. This means we have an approach which not only acknowledges the competition and negotiation across the conventional/unconventional divide but is also far more sensitive to intraprofessional divisions and tensions both within the medical community generally and within general practice more specifically. Secondly, bringing discourse to the analytical fore of a social world perspective permits the elaboration of an original analysis of the developments of direct integrative practice. An analysis which centres attention upon grass-roots doctors as opposed to focusing simply upon the elite representatives of the medical community.

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tribe, then he or she may even be threatened with exclusion'. Kilcoyne, A. and Pietroni, P. C. (1990). 'The History of the Primary Care Team'. *RCGP Yearbook*. London, RCGP. p.19.

## **2.9 Research Questions**

Having outlined the central concepts and tenets of the theoretical framework employed in this study it is now possible to define a range of specific research questions which inform the analysis of the GPs' accounts in chapters four to seven.

The analysis can be seen to operate on two levels. The first level is concerned with exposing the rhetorical tools and devices at work within the GPs' accounts. Here attention focuses upon the linguistic resources, methods and procedures of talk through which the GPs manufacture their stories. The second level of analysis builds upon this initial exposition of linguistic constructions and proceeds to examine the ideological function of these stories within the wider arena of medicine and medical worlds. This level is concerned to contextualise the GPs' talk within on-going intra- and inter-professional rivalries and debates. Building upon and reflecting this two-tier analysis the following research questions are presented.<sup>196</sup>

### **2.9.1 Examining Rhetorical Tools and Devices within the GPs' Accounts**

One line of inquiry developed in this thesis is to identify the different rhetorical devices and tools at use within the accounts. Here, attention is upon the methods by which the GPs accomplish their description of a range of relevant objects and subjects. It is suggested that accounts are not only characterised by variability and contradictions of argument but that they also contain consistencies (both across accounts and within the same individual narrative). Both of these characteristics of

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<sup>196</sup> The analysis chapters (four to seven) reflect a less simplistic and clean-cut approach. First, in the GPs talk the different resources and other procedures through which the accounts are constructed are more often than not intertwined. For example, an examination of discursive boundaries through which the GPs distance themselves from the practitioners of other medicines and professional groups is only insightful alongside an examination of the rhetorical devices through which other practitioners and medicines are presented as illegitimate. Moreover, contextualising the accounts as a means of exploring

stories inform specific research questions. Do the accounts reveal a range of interpretative repertoires which are drawn upon by this group of GPs? If so, what are these particular interpretative repertoires? And with reference to variation, in what ways does an examination of the accounts reveal a flexible employment of diverse or contrasting interpretative frameworks?

Alongside interpretative repertoires, and working in tandem with them, can be found discursive boundaries. These boundaries represent another rhetorical device through which participants construct their talk. In terms of this case study we can explore the particular boundary-work within the GPs' accounts. This raises the following questions for enquiry: What particular discursive boundaries are presented by these GPs? Are boundaries presented by these GPs in relation to practitioners of other medicines who are currently located in private practice and/or are not medically qualified? Do the GPs demarcate themselves in any significant way from any other groups of medical practitioners? Is boundary construction confined to inter-professional spheres or are demarcations produced which relate to the internal grouping of general practice itself?

Focusing upon these rhetorical resources the analysis examines the presentations of integrative practice and related themes as identified within the GPs' accounts. Questions of interest here are: How do these GPs construe integrative practice? How do they describe unconventional therapies and the unconventional medical knowledge commonly associated with these other medicines? How do they portray their own professional identity, location and role? And how do they portray

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their wider ideological function (in terms of intra- and inter-professional issues) is undertaken alongside a more detailed deconstruction of the accounts themselves.

identity, location and role to other practitioners (both within and outwith the conventional medical community)?

### **2.9.2 Putting Rhetorical Resources to Work: Legitimacy and Appropriation**

In addition, talk has an *action orientation*; these resources (interpretative repertoires and boundary constructions) are not simply employed to provide tellings, but they also play a part in accomplishing ideological tasks. For example, research has identified the use of contingent and non-contingent repertoires by scientists in their attempts to present their practices and knowledge as legitimate and that of other scientists as distorted by self-interest.<sup>197</sup> As well as asking questions about legitimating their own accounts the thesis also asks: How do the GPs attempt to present the practices and claims of other groups of practitioners as misrepresentations and therefore as inferior to their own practices?

Utilising the framework of Social World Theory it would appear that these GPs are involved in a wider process of appropriation whereby practices (unconventional medicines) traditionally associated with another world are integrated into their own professional community. As such, they face the difficulty of authenticating these ‘controversial’ and ‘exotic’ practices to others in their own medical world. How might these doctors authenticate their practice of unconventional medicine with reference to their own world of general practice? What rhetorical devices and tools do they employ in their attempt to appropriate the therapies within their own professional community?

Furthermore, what ideological functions do the GPs’ descriptions and explanations serve for this group of practitioners? How might these presentations

serve to maintain the cultural and social dominance of the medical profession within the medical arena? What implications might their constructions have for the practitioners of other medicines who are currently negotiating and competing within this arena for specific roles and locations within medicine? How, if at all, do the constructions of unconventional therapies and integrative practice relate to wider intra- and inter-professional debate and conflict within the medical arena? In what ways might the constructions of unconventional therapies represent opportunities for these GPs in terms of these debates? Do the constructions of unconventional therapy help the GPs enhance or maintain a particular identity or role and/or do these medicines perhaps provide a unique body of medical knowledge whereby the GPs can claim certain medical functions as their own? As will be seen each of the analysis chapters is organised around exploring a number of these research questions.

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<sup>197</sup> Gilbert, G. N. and Mulkay, M. (1984). *Op. Cit.* No. 32.



## **Chapter Three**

### **Methods**

### 3.1 Introduction

This chapter considers the way in which I collected, interpreted and wrote up my material in the study. Details of the philosophical approach of the methodology, the development of research tools, data collection and the analysis of the data are also addressed.

The specific research questions outlined in the thesis and the theoretical framework devised to answer these questions suggest qualitative research methods as the most appropriate means of collecting pertinent data. First, the study takes a broad constructionist approach to the topic under study.<sup>1</sup> In line with this approach, qualitative methods provide a suitable means of investigating and analysing 'indigenous typologies' – the meanings and presentations of actors themselves as they justify and explain their world – rather than simply employing those constructions imposed by the researcher.<sup>2</sup> More specifically, the primary theoretical focus of the thesis – how language is used by speakers to construct aspects of their world – led to the need to collect and analyse the talk of key informants, the two obvious methods of collecting such data being either interviewing or ethnographic fieldwork.

However, ethnographic fieldwork was omitted from the study on two grounds. First, such fieldwork proved difficult to access. Initial suggestions of the possibility of sitting in on complementary consultations with patients met with strong opposition from the GPs. The GPs claimed that the observation of consultations by myself would possibly prove detrimental to the effectiveness of the complementary treatment and suggested that my presence might disrupt or constrain patient-practitioner communication which they claim is often central to complementary therapy.

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<sup>1</sup> Here I refer to Gieryn's dichotomy between constructionist and essentialist approaches to social science. See Gieryn, T. F. (1995). 'Boundaries of Science'. In S. Jasonoff, G. E. Markle, J. C. Peterson and T. Pinch (eds). *Handbook of Science and Technology Studies*. London, Sage.

<sup>2</sup> Patton, M. (1990). *Qualitative Research and Evaluation Methods*. Newbury Park, CA, Sage.

Second, it became clear in the early stages of the study that these GPs use unconventional medicines in a restricted fashion, integrating the therapies only at appropriate times within their wider practice. Given this feature of integrative practice it was thought that ethnographic study of the GPs' use of unconventional therapies might well require lengthy periods of observation while providing only a limited opportunity for collecting pertinent data. Due to these constraints and difficulties associated with undertaking ethnographic methods within the social setting of general practice it was decided to concentrate effort upon interviews with doctors.

As explained in chapter two, in order to interpret the talk of the GPs this thesis draws upon, amongst other influences, the analytical framework developed by discursive psychologists and related discourse analysts. However, later this framework proved less fruitful with regard to analysis and interpretation of the data collected.<sup>3</sup> In a manner consistent with this style of theoretical approach, there is much overlap between the features of theory and method within this thesis; much of the outline of a theoretical framework presented in the previous chapter also touches upon a number of methodological issues pertaining to the research.<sup>4</sup> Nevertheless, this chapter provides a more in-depth discussion of the key features of the methodology used in the study.

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<sup>3</sup> For more details regarding this point see section 6 in chapter 8.

<sup>4</sup> The overlap between theory and methods within discourse analysis has been identified by writers within this tradition. For discussions relating to this point see Parker, I. (1992). *Discourse Dynamics*. London, Routledge. Wetherall, M. and Potter, J. (1988). 'Discourse Analysis and the Identification of Interpretative Repertoires'. In C. Antaki (ed.). *Analysing Everyday Explanations: A Casebook of Methods*. London, Sage. Hollway, W. (1989). *Subjectivity and Method in Psychology: Gender, Meaning and Science*. London, Sage. Furthermore, researchers have often claimed that analysis is not a separate phase in qualitative research more generally. See Bryman, A. and Burgess, R. (eds). (1993). *Analysing Qualitative Data*. London, Routledge.

### **3.2 Questionnaires: Identifying GPs for the Study**

Given the research focus of the study there was a need to identify GPs who were personally practising unconventional therapies within their own NHS surgeries. I did not have any prior contacts in the GP community and it was decided to write a letter to *all* GPs in the Edinburgh and Glasgow practice areas requesting the completion of a questionnaire. The questionnaire was posted to the 918 GPs on the medical registers for the cities (see appendix 1 for a copy of the questionnaire). It is important to stress that this section of the fieldwork was not intended to provide primary data for the study but was undertaken simply as a means of making contact with GPs practising unconventional therapies. The questionnaire was kept as short and quick to complete as possible, to encourage responses. As part of the questionnaire the GPs were asked briefly to outline any issue(s) which they perceived as important regarding unconventional therapies within general practice. The responses to this question provided cues as to the type of issues which might be raised by GPs later in interviews. A response rate of 52.7% (484) was recorded for the questionnaires. At the end of the questionnaire the GPs were asked if they were prepared to be interviewed at a later date and those who did agree were then contacted to arrange a convenient time to conduct the interview.

### **3.3 Study Group**

The study was primarily based around in-depth unstructured interviews conducted with GPs between the summer of 1997 and the spring of 1998. From the 484 respondents to the questionnaire eighty-one doctors expressed their willingness to be interviewed at a later date. Fifty-three of these eighty-one doctors were not practising unconventional therapies and twenty-eight were. The formulation of

research questions meant that I wished to interview only those GPs practising unconventional therapies.<sup>5</sup> From the 28 respondents who were personally practising unconventional medicine 25 were later interviewed, the remaining three declining to arrange interviews due to lack of time or illness.

Given the difficulty in recruiting sufficient numbers of GPs practising unconventional therapy for interview, the study did not focus particularly upon the characteristics of the GPs interviewed. However, the questionnaire did allow a few elementary characteristics to be identified. It must also be explained that these factors (such as gender and years in practice) did not play any central role in analysing the data. A thesis is obviously set quite forcefully by constraints of time. Given such constraints the thesis could not follow all avenues of research interest.<sup>6</sup>

All the 25 GPs interviewed were currently in group practices of three or more partners. All apart from three had been practising for more than five years and twenty for over ten years in general practice. The interviewees consisted of 14 male and 11 female GPs. The table below illustrates the frequencies of different therapies amongst the 25 GPs interviewed.

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<sup>5</sup> With hindsight it was not necessary to seek agreement to interview all these eighty one respondents. Instead, it would have been sufficient simply to seek agreement from just those GPs practising unconventional therapies. For more detailed methodological critique of the study see section 7 chapter 8.

**Table 1. Therapies Practised by GPs in the Study**

(Note: some GPs practised more than one therapy)

Therapy	Number of GPs Practising
Acupuncture	10
Homeopathy	16
Hypnotherapy (including Autogenic Training)	12
Neurolinguistic Programming	4

The therapies included in the study were not chosen by the researcher but self-selected in terms of the GP responses. However, it is interesting to note that acupuncture and homeopathy – two therapies which have been shown to be well represented in wider samples of GPs<sup>7</sup> - are also well represented among the 25 GPs recruited for this study.

Having collected the responses from the questionnaire, two initial pilot interviews were arranged and conducted. Data from these interviews were not analysed for the completed study but were used simply to familiarise the interviewer with taping requirements and equipment, interviewing technique and possible themes and topics which may be of interest and concern to this group of doctors. These pilot interviews also provided the chance to identify initial themes for coding.

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<sup>6</sup> For an interesting exploration of the gender specific talk of GPs see Riska, E. and Wegar, K. (1995). 'The Medical Profession in the Nordic Countries'. In T. Johnson, G. Larkin and M. Saks (eds). *Health Professions and the State in Europe*. London, Routledge.

<sup>7</sup> See Scottish Office (1997). *Complementary Medicine and the National Health Service: An Examination of Acupuncture, Homeopathy, Chiropractic and Osteopathy*. Edinburgh, Scottish Office.



### 3.4 Conducting Interviews

On meeting the interviewees I introduced myself and the broad aims of the study. An assurance of confidentiality was given in each case and enquiries as to whether the GP had any queries or questions were also made before taping any talk. Having gained consent from the doctors interviews were conducted at a time and place convenient for and chosen by the respondent. All the interviews were conducted in the practice surgeries of the GPs.

The interview length ranged from just under an hour to two hours and often varied owing to the time constraints upon individual GPs. Interviews were audio-taped with the consent of the GP involved. At the close of each interview field notes were recorded as a means of documenting the overall experience of the interview session and the key issues which had arisen from the dialogue. All tapes were transcribed to computer files shortly after interview and transcription occurred concurrently with data collection and preliminary analysis throughout the fieldwork period.

The study employed unstructured interviews. Structured and semi-structured interviewing techniques were considered too intrusive upon the GPs' narratives, given that the aim of the interviews was to produce extensive stretches of uninterrupted talk from the informants for analysis. I was primarily interested in the themes and issues which the GPs themselves introduced in their talk and as far as possible prompts were used only to ask for clarification or expansion of informants' points. The interviews did not follow an interview schedule. Instead, key themes, arguments or words as

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Thomas, K., Parry., G. and Nicholl, J. (1995). *National Survey of Access to Complementary Health Care via General Practice*. Sheffield, Medical CareResearch Unit, University of Sheffield.

mentioned by the GP were noted as the interview commenced. These notes were then consulted to further probe arguments and claims at a later stage in the interview.

Undertaking unstructured interviews allows for flexibility on behalf of both interviewer and informant.<sup>8</sup> The GPs set the details of the interview agenda and were allowed the flexibility to direct the structure and flow of the interview process. Meanwhile, this 'depth' approach to interviewing also provided flexibility for the interviewer, enabling the formulation of questions in direct response to interesting leads and issues as they were raised by the GP.

While these advantages of unstructured interviewing do make this style of approach very attractive to the overall aims of the study, I was also well aware of the difficulty of producing a 'pure' type of unstructured interview. In practical terms, the expectations and influence of both researcher and informant render the 'pure' unstructured interview an ideal type which can only be used to guide the interview process. For example, despite attempting to produce narrative which is directed by the informant the researcher does nonetheless have to probe and thereby decide what constitutes an interesting lead worthy of further investigation. In this sense, the theoretical framework developed in the study did, implicitly at least, play some role in guiding the interviews, if only in as much as it provided a focus for the interviewer in choosing what to probe further. This is a characteristic of interviewing as a method more generally.

Turning to the role and expectations of the interviewee we can identify another problem: informants expect the interview to be guided by questions set by the researcher. As Horobin and McIntosh have highlighted (also in relation to conducting unstructured interviews with GPs): '...some compromise [from a pure unstructured

interviewing style is] necessary since, apart from anything else, an interviewee expects to be asked some questions'.<sup>9</sup>

One major difficulty associated with such expectations when undertaking unstructured interviewing is commencing the actual interview. In this regard the interviewer is faced with something of a dilemma: how to initiate talk from informants and invite their tellings, yet do so in such a way as not overtly to direct their focus and themes of discussion. Of course, agreeing with key aspects of a symbolic interactionist approach to talk and interaction, I was aware that the interviews were by their very nature 'joint productions' between the GPs and myself.<sup>10</sup> Fortunately, a strategy whereby I could minimise my part in such story production developed somewhat by accident at an early stage of the fieldwork. As preparation for the pilot interviews I produced a rough list of the key themes which I suspected (from clues in literature and data from previous studies) might be the focus of the GPs' talk.<sup>11</sup> One area which I initially suspected might be worth exploration was the motivation for, and the means by which, these GPs became interested in, and started to practice, unconventional medicine; this seemed as good a topic to start the interview as any other. It soon transpired, however, that this opening topic was more useful than I had first imagined.

The topic of how these GPs became involved in unconventional practice did not in itself produce data which fitted within the focus of the analysis presented in the thesis; the doctors presented 'personalised' reasons for getting interested in or coming into contact with other medicines (e.g. family or friends received treatment) which

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<sup>8</sup> Seale, C. (1998). 'Qualitative Interviewing'. In C. Seale (ed.). *Researching Society and Culture*. London, Sage. Fontana, A. and Frey, J. H. (1998). 'Interviewing: the Art of Science'. In Denzin, N. K. and Lincoln, Y. S. (eds). *Collecting and Interpreting Qualitative Materials*. London, Sage.

<sup>9</sup> Horobin, G. and McIntosh, J. (1977). 'Responsibility in General Practice'. In M. Stacey, M. Reid, C. Heath and R. Dingwall (eds). *Health and the Division of Labour*. London, Croom Helm. p. 93.

<sup>10</sup> See Plummer, K. (1995). *Telling Sexual Stories*. London, Routledge.

were distanced from professional role and identity. Nevertheless, invariably, in the course of recounting their initial contact with unconventional therapies the GPs would (in one guise or another and explicitly or implicitly) begin to give an account of their unconventional practice, describe their own identity and that of others, and outline the social terrain associated with these identities. What had started out quite innocently as purely a topic for beginning the interview provided a whole host of material for further exploration later in the interview.

This last point relates to an important observation I made very early in the interviewing schedule (during the pilot interviews). I quickly began to notice that direct questions relating to identity, role and the nature of the therapies elicited overtly ‘diplomatic’ strategic answers, or, worse still, a refusal to answer the question at all. By contrast, allowing the GPs simply to describe aspects of their work with no direct focus provided by myself produced much richer and more valuable data. As a result of these experiences I concentrated my efforts upon *facilitating* the doctors’ talk as much as possible. Furthermore, these experiences also reinforced my understanding of the role of language in society: that to claim an ideological dimension to all talk is not necessarily to argue that this dimension is always (or predominantly) known to the speaker. Much of the performative nature of talk is unknown to the speaker due to taken-for-granted assumptions which are embedded in that individual’s immediate local culture. The very fact that the doctors’ descriptions of their work (undirected by the interviewer) provided such rich and valuable data was due to the GPs’ inability to identify the ideological nature of such descriptions and therefore the GPs’ willingness to talk freely.

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<sup>11</sup> As mentioned earlier, the actual interviews used for data analysis followed an unstructured model and no such list of themes was used in these interviews.

Another issue which also relates to the problem of diplomatic responses is the relationship between, and the status of, the two participants in the research process and how this might influence the talk produced. This issue centres upon the influence of 'audiences' upon speakers; to some extent, speakers pitch and adapt their arguments and claims to their perception of the target audience. This issue was a concern when conducting the interviews for the study. I was concerned that the doctors might perceive me as either an ally of non-medical therapists and/or an opponent of medical integrative practice. In response, while providing the doctors with a brief outline of the role of the thesis work, I always made it clear to the doctors at the start of every interview that I have no formal connections to any medical group (I am neither trained nor affiliated to either the conventional or unconventional medical community).

### **3.5 Transcripts**

When measured against the standards of conversational analysis and discursive psychology the transcription used in this thesis is of fairly unconventional design. This is because I began to find these particular approaches to theory and data analysis less useful. Due to the theoretical framework and objectives of the study I did not concern myself with the 'micro' details of talk such as repetitions, extended pauses and overlappings. Instead, I concentrated on casting the talk as conversational speech. This orientation follows the broad approach of Billig's rhetorical psychology which focuses upon argument and counter argument rather than the building blocks of 'doing' talk.<sup>12</sup> In keeping with this focus, I did not set out to capture the finer details of talk on the transcript files but instead simply to register the general repertoires and

arguments employed by the GPs to present subjects and objects in their talk. This approach sits comfortably alongside the approach to the coding of the talk outlined in the next section of this chapter. Nevertheless, it is useful for the reader to be aware that the following guidelines have been used for both the complete transcripts and the extracts presented in the analysis chapters that follow:

[x]	= Researcher's comments
...	= A pause in the talk (exact time lapse not recorded)
[...]	= Words I was unable to transcribe due to background noise, etc.

### 3.6 Coding and Data Analysis

Another important process which requires explanation is how codes and analytical themes were developed from the raw data in the transcripts. Essentially, codes were developed in a cumulative manner; as each interview was completed a note was made of the types of categories and codes which were emerging. In this sense, while mindful of the role theory plays at *all* stages of the research process (the coding was undoubtedly influenced by the theoretical framework developed in the study), an attempt was made to let concepts emerge out of the research context rather than *a priori*. Codes were identified in relation to particular words, phrases and arguments within the GPs' talk (in line with Billig's work). In this way repertoires were identified as coding proceeded.

In order to explain in more detail how codes were developed in the study it is useful to provide an actual example from the data. All the GPs described and

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<sup>12</sup> See Billig, M. (1987). *Arguing and Thinking: A Rhetorical Approach to Social Psychology*. European Monographs in Social Psychology. The influence of Billig's psychological approach upon



explained (in one form another) a medical approach which was identified as 'holistic'. Some of the doctors actually used the term 'holistic practice', 'holistic medicine' or 'holism' to describe a style of medicine and this type of label provided an early indication that different sections of talk from the GPs' accounts could form a code for analysis entitled 'Holism'. However, some other GPs did not use such labels yet still referred in their talk to those features associated with such practice (as identified from the GPs' talk). For example, some spoke in less specific terms of treating the whole person, of whole person medicine or of perceiving the patient as an individual at not only a physical level but also on other levels such as the social and psychological. Following numerous readings of the transcripts all these sections of talk were eventually incorporated into the code of holism.

The particular code of holism was also developed in terms of numerous subcodes. First, two styles or definitions of holism emerged from closer examination of the GPs' accounts. Some GPs define holism as a set of practice features such as treating the patient as an individual and acknowledging the social context of their illness, while others argue that holism is the ability to heal patients using an array of different treatments. In response the code of holism was divided into two respective subcodes: 'qualitative holism' and 'quantitative holism'.

The code of holism was also further complicated with the identification that different GPs direct and appropriate their talk of holism to different issues and arguments. For example, all the GPs referred to holism in an attempt to authenticate unconventional therapies to their branch of medicine. Meanwhile, some GPs also employed the rhetoric of holism as a means of attacking evidence-based medicine and also to present an identity separate from the hospital paradigm. In response to these

characteristics of the data the code of holism was also further subcoded with quotes placed under the headings 'Holism and GP/Hospital Divide', 'Holism and Appropriation' and 'Holism and EBM'.

Transcripts were kept on separate word processing files and a hard copy printed. Extracts of the GPs' talk were coded by hand on each individual transcript and then cut and pasted from their original word processing file to a coding file with a particular heading, e.g. 'Holism' (talk relating to more than one code was allocated to more than one file). Moreover, sub-codes were also established within each separate file and these provided the rough outlines of the sections and section headings as later written up in the analysis chapters. The development of codes also involved other researchers. Issues regarding the coding of the data and actual codes being developed were discussed with other researchers and their comments fed back into the coding process.

There was a remarkable degree of similarity and coherence between the issues GPs raised in the interviews. Most GPs actually covered all the coding themes which are discussed in the analysis chapters. However, variation is obviously to be expected across individual accounts and some GPs did fail to mention one or two of these themes in their interviews. Such differences across accounts are also important and this was not seen as a deficiency in the data collection process. In order to maintain a respondent-led discussion no attempt was made at any time in the interviews to introduce topics which were not initiated by the GPs.

Having identified a range of codes with which to categorise the GPs' talk the next stage of the research was to group and thereby allocate these codes to wider themes and ultimately to analysis chapters for the writing up process. This allocation

ensured that the conceptual categories produced in the study were grounded in both the theoretical perspective employed and the data collected.

The analysis chapters (chapters four to seven) were not conceived or written up in the order they are presented in the thesis. Initially chapters four and six were written – at this stage in writing up and analysing the data my focus (influenced by SWT and Gieryn's boundary studies) was primarily upon discerning and exploring episodes of boundary construction from within the GPs' accounts. The two main themes of these chapters were identified – demarcation from lay therapy on the one hand and distancing from hospital doctors on the other – and a selection of the coding files which related to these themes were analysed in order to plan and write the chapters. Following completion of these two chapters I then reviewed the remaining categories for further broad analytical themes. It became apparent that a number of the remaining themes, whilst related very closely to the notion of boundary construction, would be better understood in terms of the broad themes of appropriation and authentication as outlined in SWT. These themes became the focus of chapter five. Finally, the topic of evidence-based medicine and its relationship to unconventional therapy and clinical practice more generally provided the remaining coding material and this formed the material covered in chapter seven. This topic also comfortably fitted with the theoretical framework developed in the study, providing an example of internal social world divisions and the identification of intraprofessional strategies within that world.

### **3.7 Reliability, Validity and Generalisability**

Some within the quantitative tradition of social science research have criticised qualitative research for what they perceive to be the bias of 'unscientific'

methods.<sup>13</sup> While such criticism fails to appreciate the underlying rationale and philosophical concerns of qualitative research methods, it is nonetheless important that qualitative researchers protect against and attempt to minimise researcher bias in the analysis of data and presentation of findings. In particular, the process of identifying and establishing coding categories from interview transcripts requires strategies to encourage rigour and this was a major concern with regard to the present research project. In order to enhance the reliability of the analysis an independent assessment and analytical examination of sections of the interview transcripts was undertaken by qualitative researchers in addition to the authors. A number of colleagues in the Department of Sociology and the Science Studies Unit at the University of Edinburgh were approached and agreed to read through sections of transcripts.<sup>14</sup> These colleagues then met with the author to discuss (and critically appraise) the proposed coding schemes and categories produced. These meetings confirmed the reliability of the codes produced by the author.

Internal validity – the degree to which findings correctly map the phenomenon in question<sup>15</sup> – has also been considered in order to ensure the rigour of the project. One particular procedure was undertaken as part of the present research to improve the validity of the codes, analysis, and the subsequent findings produced from the data collected. Specifically, following the creation of coding files and preliminary analysis I searched the data collected for evidence of negative cases (sections of the GPs' talk which disproved the analysis and findings produced), a procedure also encouraged by

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<sup>13</sup> For discussion of these criticisms see Mays, N. and Pope, C. (1995). 'Rigour and qualitative research'. *British Medical Journal* 311: 109-112.

<sup>14</sup> These transcript extracts were chosen in some cases at random and in fewer cases were specifically targeted by the author as sections of talk which were proving more difficult to code and analysis.

<sup>15</sup> Denzin, N. and Lincoln, Y. S. (eds) (1998). *The Landscape of Qualitative Research: Theories and Perspectives*. London, Sage. p.186.

Billig's focus upon argument and counter-argument.<sup>16</sup> Such a search produced no negative cases.

Another method by which some researchers attempt to improve the internal validity of their work is through feeding analysis and interpretation back to the respondents for scrutiny in the hope that the analysis will prove agreeable to the informants involved.<sup>17</sup> This procedure has not been undertaken in this project. The theoretical approach developed in this thesis, in particular the conception of the role of language in society, warns against this strategy. The ideological dimension of talk is not necessarily the conscious strategy of the speaker; one important aspect of being a member of a social world or interpretative community is that certain core assumptions and interpretations of the world are shared with other members – these members hold 'naturalised attitudes' from within their common social space. This means that many aspects of the analysis produced in this thesis would not be familiar to the GPs and there is a serious possibility that analysis might once again fall back into the pure description produced from within the world under study. While a major aim of in-depth interviewing is to help the researcher enter the social world of the informant it is also important that sociology appreciates the benefits of being a 'stranger'; interpreting the culture of general practice through GPs' talk is positively aided by the researcher's not being a part of that world and the issue of validity must essentially remain an internal issue within the sociological discipline.

Another concern when undertaking qualitative research is that of ensuring the generalisability (external validity) of the analysis and findings produced; the representativeness of the study group. The findings produced from the examination of

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<sup>16</sup> Billig, M. (1991). *Ideology and Opinions: Studies in Social Psychology*. Oxford, Blackwell.

<sup>17</sup> McKeganey, N. P. and Bloor, M. J. (1981). 'On the retrieval of sociological descriptions: respondent validation and the critical case of ethnomethodology'. *International Journal of Sociology and Social Policy* 1: 58-69.

the study group can be generalised to other GPs personally practising complementary therapies in their surgeries – the analysis of their talk does reveal some of the prominent rhetorical resources and arguments as drawn upon by members of this subworld. To explain, as outlined in chapter two, talk is primarily based upon two elements: language use and language resource. This second element – language resource – refers to the rhetorical patterns which are evident across the accounts of actors located in the same interpretative community. Following this line of approach, it is reasonable to assume that those rhetorical resources which are drawn upon by the GPs interviewed for this study are resources which are also drawn upon by others within this subgroup more generally; here we have the link between the individual GPs' accounts and their cultural or world location.

Having outlined some of the central methodological issues involved in the study and the different phases of the research process (from data collection through to coding and the production of analytical themes) it is now appropriate to present the analysis chapters generated from the transcripts of the GPs' stories.



## **Chapter Four**

### **Distancing Integrative Practice from Non-Medically Qualified Therapists**

## 4.1 Introduction

This chapter focuses attention upon a specific area of boundary work identified within the GPs' accounts of their integrative practice, namely, the lay/GP divide.

More specifically, it illustrates how the doctors employ a number of different repertoires and rhetorical devices with which to distance themselves and their practice of unconventional therapies from that of non-medically qualified therapists.

Furthermore, the GPs delineate what they perceive as *legitimate* and *authentic* unconventional practice as distinct from those clinical techniques of lay therapy which they portray as ineffective, misguided, dangerous and ultimately in need of revision.

Contextualising these different rhetorical presentations within the framework of more formal claims of different medical groups, the ideological dimension of this lay/GP divide is exposed. In particular, the analysis demonstrates how the GPs' descriptions of lay practice and their perceptions of unconventional therapies more generally can be seen as an attempt to present the GP as an essential component of good effective unconventional therapy.

## 4.2 Complementary as Opposed to Alternative: Perceptions of Styles of Practice

I'm an allopathic doctor. I use it as a complementary therapy rather than as an alternative. I'm not a homeopath I'm an allopath who uses homeopathy .... alternative replaces, complementary is an add on.<sup>1</sup>

I've always considered these therapies complementary in the sense of being additive to orthodox medicine.<sup>2</sup>

There has been much discussion and debate regarding a suitable and appropriate nomenclature for the therapies and medicines which are currently practised predominantly outwith the medical profession. Concern has been raised over the wider connotations of different labels; however these have until now been mainly academic wrangles.<sup>3</sup> Nevertheless, different labels and their respective connotations are also powerful discursive tools which can be deployed by different groups and their members who are actively involved and enmeshed in the arena of health care itself<sup>4</sup> and the analysis presented here illustrates the role of different terminology and titles in the boundary work of 'rank and file' doctors.

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<sup>1</sup> Dr 2.

<sup>2</sup> Dr 18.

<sup>3</sup> See Sharma, U. (1992). *Complementary Medicine Today: Practitioners and Patients*. London, Routledge; and Saks, M. (ed.) (1992). *Alternative Medicine in Britain*. London, Clarendon Press.

<sup>4</sup> For example the BMA makes a clear distinction between the labels of alternative and complementary, see BMA (1993). *Complementary Medicine: New Approaches to Good Practice*. Oxford, Oxford University Press. p.6. In addition, Vickers states from within the orthodox camp, 'many of the therapies are called alternative medicine by some people. This seems to suggest that they are something you might consider doing instead of seeing your doctor': Vickers, A. (1993). *Complementary Medicine and Disability*. London, Chapman and Hall. p.8. While some writers have demarcated the unconventional medical sector into those therapies that are deemed 'alternative' and those deemed 'complementary', the position adopted in this thesis falls more in line with Atkinson's suggestion that both labels can often (and often are) applied to any one therapy. She puts it like this: 'complementary medicine is usually applied to treatments that are carried out "alongside" or "complementary" to orthodox medicine, e.g., osteopathy, where the practitioner will expect patients to continue any medication. "Alternative medicine" is the term applied to treatments that are used 'instead' of orthodox medicine, e.g., herbal or homeopathic medicines. however, complementary medicine can also be used "instead of" and alternative medicine "as well as"; for example, acupuncture is alternative if used as part of Traditional Chinese Medicine, whose approach is quite different from Western medicine but it can also be used alongside orthodox medicine by Western doctors in pain relief clinics'. Atkinson, K. (1996). *Alternative Medicine: Availability and Quality of information for Health Authorities, GP Fundholders and the Public*. Unpublished MSc Dissertation, Department of Information and Library Studies, University of Wales, Aberystwyth. Other writers have portrayed the therapies as representing one particular side of this dichotomy. For example, Joyce claims, 'by whatever generic name they are known, these [complementary therapies], are truly complementary and not, as the common synonym

The vast majority of the GPs in the study place great importance upon the use of an appropriate title for the therapies they are developing.<sup>5</sup> Effectively, the GPs perceive their style of therapy and practice as *complementary*, while in contrast they understand lay therapists to be involved in *alternative* therapy and likewise to be *alternative* practitioners.<sup>6</sup> The GPs construe these two styles as fundamentally opposed and therefore as mutually exclusive in practice.

One GP practising acupuncture, homeopathy and hypnotherapy provides a relatively explicit definition of the two styles of alternative and complementary practice and their foundations, and in so doing exposes this discursive construction of complementary therapy as requiring an acceptance of the potential benefits of a conventional approach. He explains:

if it's complementary then they have to take on board what other allopractic medicine is offering and be willing to work along with that, and if you are then it's complementary. If they believe allopractic medicine is negative and is destructive and shouldn't ever be entered into then they're alternative... the contrast is where you're starting. If the starting point is that all men are evil then every man is evil, if your starting point is that there are evil things in some men then no that doesn't mean that all men are evil and I would see that in that kind of way, you know that allopractic medicine...there's a lot of stuff in it that's useful and creative and positive and therefore I'm complementary in that I would utilise these things as part of my armamentarium?<sup>7</sup>

Here the GP's talk illustrates a degree of reflection regarding these two constructions of styles of practice. He does not perceive these two styles as necessarily tied to the two groups of medical and non-medical therapists. Instead, within this presentation,

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would have it, alternative to orthodox medicine': Joyce, C. R. B. (1994). 'Placebo and Complementary Medicine'. *Lancet*, 344: 1279-1281. p.1281.

<sup>5</sup> This insistence upon 'correct' labelling was even evident before interviews commenced with over a third of the interviewees claiming the therapies were complementary and not alternative. On many occasions contact phone calls with the subjects reinforced this point.

<sup>6</sup> A couple of GPs were less reflective and did not employ specific labels to demarcate their practice from that of the non-medical. However, these doctors did construct *their own* clinical practice of the therapies in terms of the *complementary* style referred to in this chapter.

<sup>7</sup> Dr 15. Dr 6 outlines this 'complementary' role for her homeopathy. She states, 'when I started homeopathy I thought oh god this is, this *is* medicine *but* it's adding on top of the medicine I know'.

lay therapists themselves are capable of a 'complementary' approach to the therapies as long as they conform to certain guidelines. This portrayal perpetuates the significance of conventional medical knowledge and therefore sustains the dominance of GPs over medical decision-making and the direction of treatment. This description of alternative and complementary styles of practice is similar to a construction found within the BMA report of 1993. The report employs similar language when it explains complementary therapies as 'those which can work alongside and in conjunction with orthodox medical treatments' and alternative medicine as 'given in place of orthodox medical treatment'.<sup>8</sup> Furthermore, this report too acknowledges that such styles or approaches to practice can in the case of many therapies be primarily dependent upon the practitioner's discretion. However, what is evident from most of the GPs' accounts analysed here is how the banners of alternative and complementary practice are more forcefully employed as marking a lay therapist/GP divide. In the majority of cases the model of alternative therapy acts as a powerful rhetorical construction with which lay therapy is characterised as deficient and potentially highly dangerous.

Around the demarcation of styles of unconventional practice the GPs employ a number of discourses with which to legitimate their own development of the therapies and to deauthenticate the work and role of non-medically qualified therapists. It is to this collection of different rhetorical devices and interpretative repertoires that this chapter now turns attention.

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<sup>8</sup> BMA (1993). *Op. Cit. No. 4*, p.6.

## 4.2.1 The Centrality of a Conventional Diagnosis and a Conventional Medical

### Context

At the heart of the alternative-complementary divide is a description of the importance of the conventional diagnosis. Some GPs explain how they see their practice and role as built primarily upon being a diagnostician. To quote a GP acupuncturist:

my first job of all as a Western doctor is to diagnose and say yes I think this is a tension headache, there are a number of alternative treatments for you or I don't think this is a tension headache I think we should be investigating this more deeply and organising CAT scans. Perhaps my main job, my first job is diagnosis and *that's the most important thing I do*.<sup>9</sup>

Drs 11 and 14 express a similar role for themselves based upon the importance of conventional training. Dr 11 claims: 'there is the fact that, you can't get away from the fact that we do five years training and many many more years in practice assessing what the actual problem is before dishing out something'.<sup>10</sup> Dr 14 reiterates this point in the following terms:

I do think you need to be trained properly to do it, I mean I think that's quite important and I mean my medical degree is my basic degree and to be fair that is probably what I'd use most in practice up to a point for traditional illness.<sup>11</sup>

While many of the GPs note that there are alternative diagnostic systems associated with certain unconventional medicines,<sup>12</sup> these are often used to contrast the GP approach to the therapies to the approach of the non-medically qualified. As one GP acupuncturist explains:

I suppose in the process of diagnosis it's very much Western medicine. I mean if a patient comes to me with let's say neuralgia or an inflamed joint I would

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<sup>9</sup> Dr 24

<sup>10</sup> Dr 11.

<sup>11</sup> Dr 14.

<sup>12</sup> With regard to the therapies analysed in this study this refers to homeopathy and acupuncture, while outside the remits of this study there are a range of therapies that are primarily diagnostic in role, e.g. iridology.



use Western medicine including if necessary blood tests and x-rays to make the diagnosis. I wouldn't, as a traditional Chinese healer would, use appearance of the tongue or twenty one different pulses to try and determine a diagnosis, in terms of yin yang imbalance, you know I wouldn't. My diagnosis is very much based on erm traditional Western scientific principles.<sup>13</sup>

Images of the scientific approach of conventional medicine, with particular reference to diagnostic procedures, pervade much of the GPs' boundary construction between lay and general medical practice. Whereas many of the GPs demonstrate a notable lack of concern in explaining the therapies theoretically in scientific terms, they nonetheless still employ the rhetoric of science as a means of underpinning and contextualising the therapies and as a means of distancing their practice from that of lay therapists. The discourse of science is exercised not so much as a means of understanding the therapies in terms of explanations but as a means of appropriating and authenticating the unconventional therapies *in practice*.<sup>14</sup> Dr 3 exemplifies the 'work' of this rhetoric of science with regard to the GP's diagnosis and its necessity alongside unconventional therapy when she states with regard to complementary practice:

I think *science* gives you confidence [with complementary therapy]. I think if you look at somebody and think this person's for example hyperthyroid and you check the thyroid function and you *scientifically* confirm this then obviously you can bang on in there and treat it with great confidence. If you couldn't check the bloods you would be treating it expectantly and hopefully and seeing if there was a clinical improvement so yeah the *scientific* side of it is important. It's important for the confidence of both people that you've got the right diagnosis.<sup>15</sup>

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<sup>13</sup> Dr 18.

<sup>14</sup> This stress upon the practical application of the therapies rather than the theoretical and philosophical underpinnings to their practice is a powerful rhetorical device which is identified as flowing through much of the GPs' talk. It is a theme which is also touched upon in later sections of this chapter.

<sup>15</sup> Dr 3. Dr 13 makes a similar claim with regard to her homeopathy. She suggests, 'if you're looking at the complex situation you do need to have that background knowledge, the conventional training, for a homeopathic approach'.

Here there is a suggestion that scientific checks and confirmation, at least as a basis to certain medical practices, enhances the utility and effectiveness of unconventional therapy. Analysed in these terms we can see how the notion of *complementary* practice is one which implies the domestication of unconventional therapies within a wider framework of conventional scientific medicine. *Complementary* therapy, as constructed in the accounts of these GPs, implies a limitation to unconventional practice - a limitation which is perceived by these conventional doctors as far more restrictive than alternative practitioners acknowledge or care to promote. Here we have a reference to the suitability and appropriate context of these therapies.<sup>16</sup>

Another GP refers to what she sees as the *medical context* that general practice provides for the therapies, implying that lay therapists are thus excluded from this legitimate practice environment:

I retain an open mind but the lay homeopaths, I think, I believe practise homeopathy slightly differently, differently to the way we've been taught. I don't want to comment too far on that, I just feel that to keep it in context it should be people with a medical background...because that's where we're using it, we are using it in the medical context.<sup>17</sup>

Dr 7 proposes a similar medical/non-medical divide, but in this case 'medical training' is seen to encompass not only GPs but also nurses and members of other sub-professions. She states:

when I go to the homeopathic course there are vets, there are nurses, I think there were a couple of pharmacists there, you know, so different people. Although they were sort of medically qualified, they weren't doctors as such, erm, and certainly if they do their training within the sort of within that umbrella of medical training then that's fair enough.<sup>18</sup>

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<sup>16</sup> These themes will be explored in more detail in chapter five when attention is focused upon the GPs' constructions of their clinical reality of integrative practice.

<sup>17</sup> Dr 9.

<sup>18</sup> Dr 7.

While proposing a legitimate role for others with regard to complementary practice, this talk still positions lay therapists as standing outside the ‘umbrella’ of acceptable training and therefore as non-legitimate practitioners.<sup>19</sup>

There is a concern among many of the GPs that lay therapists are ill-equipped to deal with illness which is predominantly physical in nature. In this sense, while illness is explained as multidimensional or multifactorial, the GPs nonetheless portray the physical foundations of ill-health as the most serious and crucial aspects to be identified and responded to in treatment. A case in point which one GP presents is the treatment of cancer. He says, ‘I would think there are warning signs for underlying disease that can be treated very well with allopathic medicine if you catch it early...homeopathy doesn’t cure cancer so where lay homeopaths may say it does, you know I wouldn’t agree with that’.<sup>20</sup> The importance of examining pathology and the physical element of disease is further compounded by some GPs via the presentation within their accounts of such notions as the root cause, underlying basis or actual problem of much illness. Furthermore there is a presentation of the conventional diagnosis, tailored to detecting such elements of illness, as an altogether more ‘deep’ and ‘thorough’ investigation than any enquiry offered by lay therapists.<sup>21</sup> One respondent who practices homeopathy explains her concerns regarding lay therapists and the procedure of diagnosis when she says:

one is wary that lay homeopaths don’t have a medical background and if somebody is consulting with a, you know, something, the rule is exclude anything physical...you don’t go in with homeopathy until you’re absolutely sure there’s no physical remediable cause that conventional medicine should

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<sup>19</sup> It is interesting to note that a couple of GPs did see a role for nurses in practising complementary therapies. However, the vast majority perceive the general practitioner as the most suitably qualified health care professional to offer the therapies to patients.

<sup>20</sup> Dr 12.

<sup>21</sup> This language is used by many of the GPs including Dr 2, Dr 7 and Dr 13.

be addressing and you do any investigations and examinations and the rest of it before you go in with homeopathy.<sup>22</sup>

Dr 21 also outlines what she sees as a crucial distinction between lay practice and the approach of the general practitioner:

I suppose one would resort to the medical model in that I would have to, I would like to think that I would, you know, I wouldn't miss serious pathology, that I wouldn't be treating someone with a homeopathic remedy who should be you know having their cancer removed sort of thing. I would say that's a safeguard for the patients in that respect that there is pathology that goes on which needs traditional medical and surgical treatment and erm, it may be that an unmedically qualified homeopath may miss symptoms which should be properly investigated.<sup>23</sup>

Dr 12 employs this rhetorical device to justify his integrative practice:

I think you have to have a degree of medical knowledge to make up the diagnosis, to decide what, what the, you know, you have to make a diagnosis initially and that's why general practice is a very useful place for complementary therapies to be done.<sup>24</sup>

The extract below illustrates how a similar rhetorical construction is employed by some of the GPs with regard to their practice of acupuncture:

I suspect that there's always the chance that, you know, someone'll have cancer that's causing their root problem and if the lay person's not very open to that there's always the possibility they'll delay a diagnosis or something where I kind of hope that we would, you know, have ruled that out or thought about it and considered it and everything before we start just drilling people with a course of acupuncture.<sup>25</sup>

#### **4.2.2 Safety and Risk**

From the four quotes directly above we can identify the use of contrasting rhetorics of safety and risk. These complementary interpretative frameworks are a major tool through which the GPs construct the boundary between general practice and lay therapy and problematise the practice of the non-medically qualified. These

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<sup>22</sup> Dr 9.

<sup>23</sup> Dr 21.

<sup>24</sup> Dr 12

<sup>25</sup> Dr 11.

rhetorics are in line with the suggestions and concerns of some medical commentators more formally involved in complementary therapies.<sup>26</sup> Such writers have highlighted that with the growing popularity of these ‘other’ medicines ‘there is increasing potential for public harm with misuse of (unconventional) practices’.<sup>27</sup> The current level of lay understanding of the dangers of complementary therapies is seen as inadequate and there have been calls for further research to investigate both the potential direct and indirect risks of these therapies.

Many of the GPs talk of the risk, dangers and the potential harm of lay therapy. To quote one GP interviewed, ‘[lay therapists] are not approaching it from the medical point of view and it’s kind of the safety first attitude really’.<sup>28</sup> One way in which these rhetorics are employed, as illustrated above, is through the doctors highlighting potential dangers linked to the specific task of diagnosis, and as such they highlight their perceptions of the indirect adverse effects of the medicines.<sup>29</sup> This perception would seem to rest upon a notion of lay therapy as ‘narrow’, ‘fixed’ or ‘restrictive’.<sup>30</sup> As one GP practising acupuncture, homeopathy and hypnotherapy claims: ‘I just think that diagnosis is so *multifactorially real* that you actually need to have more training than you can have without being medical and that’s not saying that we’re doctors and they’re not but nevertheless we are doctors and they’re not’.<sup>31</sup> Here the GP portrays

<sup>26</sup> Ernst, E. (1995a). ‘Bitter Pills of Nature: Safety Issues in Complementary Medicine’. *Pain* 60: 237-238. Ernst, E. (1996). ‘Direct Risks Associated with Complementary Therapies’. In E. Ernst (ed.). *Complementary Medicine: An Objective Appraisal*. Oxford, Butterworth-Heinemann. Jonas, W. B. (1996). ‘Safety in Complementary Medicine’. In E. Ernst (ed.). *Ibid.* Ernst, E. (1995c). ‘The Risks of Acupuncture’. *International Journal of Risk and Safety in Medicine* 6: 179-186.

<sup>27</sup> Jonas, W. B. (1996). *Op. Cit. No. 26*. p.126.

<sup>28</sup> Dr 9.

<sup>29</sup> To borrow some comparable terminology from the medical literature. This is a definition of adverse effects that has been outlined by W. B. Jonas. As Jonas defines indirect risks: ‘Indirect adverse effects are those events that occur because of the delivery practices of the therapy or diagnostic procedure in the context in which the practices apply’, Jonas, W. B. (1996). *Op. Cit. No. 26*. p.130.

<sup>30</sup> The use of such rhetorical constructions is given more detailed consideration in a later section of this chapter.

<sup>31</sup> Dr 10.

diagnosis as a complex process that is beyond the scope of alternative lay practitioners. The use of the word real would seem to be of major significance in this description. This word creates a demarcation between the GP's diagnosis which is seen as authentic and grounded in the *correct* perception of illness and medical complaints, and the potential diagnostic attempts of lay therapists which are perceived as fundamentally less all-embracing and thereby insubstantial.<sup>32</sup> Formal medical literature supports this rhetorical construction with some commentators suggesting the diagnostic tools associated exclusively with alternative practice carry the very real 'risk of misinformed applications and misdiagnosis'.<sup>33</sup> GP 10 later remarks with reference to lay therapists and their approach in practice: 'I think they use the medicines slightly differently because their diagnosis is slightly more *shuttered* and they don't have a wider concept'.<sup>34</sup> Along similar lines, a GP acupuncturist explains what he sees as a concern in relation to the practice of acupuncture:

my real concern would be if we don't apply a good scientific basis then we'll miss genuine pathology. I mean if somebody goes up with lets say with a pain in some part of their anatomy and the acupuncturist purely treats the symptom of pain rather than applying good scientific diagnosis to determine whether or what's the cause we'll make mistakes.<sup>35</sup>

Some of the GPs refer to specific practice experiences and encounters with patients as evidence of what they perceive to be the potential and very real dangers of non-medical therapy. One doctor practising homeopathy explains his fears of lay therapists mislabelling complaints:

what worries me a lot with the lay homeopathic person is, er, not getting the diagnosis right, you know a lot of, I suppose my medical knowledge is are you

<sup>32</sup> This use of the word real also links to the imagery of lay therapists as detached from reality as aloof etc. and general practice being sensible and based in the community, this is a theme I explore more in a later section of this chapter. This presentation of diagnosis is a classic example of what Potter refers to as category entitlement. See Potter, J. (1996). *Representing Reality*. London, Sage. p.133.

<sup>33</sup> Jonas, W. B. (1996). *Op. Cit. No. 26*. p.135.

<sup>34</sup> Dr 10.

<sup>35</sup> Dr 18.



dealing with something serious? you know, if somebody comes to you with urinary symptoms or something like that am I treating this with homeopathy or has somebody got a bladder cancer? That's the worry on the lay side. I mean I've seen people who have come to me having had lay homeopathy and they've come to me with a set of symptoms, you know, for years and I've examined them and found serious illness. Now that worries me a lot.<sup>36</sup>

A GP acupuncturist outlines his experience of patients who have been treated by non-medical homeopathic therapists, the potential problem of misrepresentation in lay therapy,<sup>37</sup> and how this has shaped his perceptions of referrals:

referring to a non-medically qualified, I'm quite unhappy about because I have had anecdotal evidence of patients who have had tumours who have been going for homeopathic treatment. The lay person hasn't known enough to pick up that there's been something wrong and the patient's been very unwell, whereas a medically qualified person would have picked that up.<sup>38</sup>

There is a suggestion by some GPs that once diagnosis has been undertaken by a medically trained practitioner the patient should not then be discouraged from seeking the services of lay therapists. As one informant explains:

That's not to say that someone who already has a diagnosis or many simple diagnoses can't be handled by people who aren't medical, but I think at the day, the actual unravelling of the various strands that go with the diagnosis does need more, so I think it is perfectly acceptable to be treating things that don't have other risks surrounding them and I think that, you know, non-medical homeopaths treating disorders is perfectly acceptable and I think it's people's right to choose.<sup>39</sup>

And another puts it like this:

I think there are certain signs that just need to be investigated and if you go into your GP and your GP, you know, worked this out and you still have this problem that's fine, you know, I think there are a lot of things which your standard medicine doesn't have the answer for, so I think if people go along to the GP and say what do you think if I tried homeopathy, I think that's fine.<sup>40</sup>

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<sup>36</sup> Dr 20.

<sup>37</sup> This term of misrepresentation is clearly defined and explained by Jonas. As Jonas writes, 'misrepresentation of ineffective therapies can result in harm if truly effective therapies are not discovered or applied for the alleviation of the condition', Jonas, W. B. (1996). *Op. Cit. No. 26*. p.131.

<sup>38</sup> Dr 23.

<sup>39</sup> Dr 10.

<sup>40</sup> Dr 12.

These accounts do introduce a notion of tolerance of the lay therapist. A few of the GPs equally present their perceptions towards ‘safe’ lay therapy in terms of indifference. However, lay therapy, as described by these GPs, is not to be seen as legitimate *per se*; lay practice is tolerated after, and only after, conventional medical treatments have been undertaken and conventional medical opinion sought. As this chapter will later illustrate, all the GPs, often through the employment of different yet related rhetorical devices, not only demarcate lay practice from their own but also proceed to project it as inferior and illegitimate when compared to their own ‘complementary’ practice; a core strategy within the accounts would seem to be the problematisation of non-medically qualified therapists and their practice. Moreover, the sign of tolerance towards lay therapy displayed in the few quotes above is not shared by the majority of GPs; lay therapy is openly criticised in the bulk of the accounts and not classified as an option for patient care (certainly not in the sense of receiving approval from within general practice). The rhetoric of safety and the associated construction of ‘risk’ attributed to lay therapy are employed by these GPs as a means of justifying and explaining their objection to lay practice and their insistence that they ‘would rather send or be happy with the patient going to medically qualified [therapists]’.<sup>41</sup> Thus, while there is evidence of a growing number of referrals for complementary therapies by doctors generally,<sup>42</sup> the majority of the GPs interviewed oppose referrals to lay therapists and, moreover, many claim to have no contact with lay therapists in their area. This may be due to the fact that these GPs, practising complementary therapies and thereby entangled in the translation and appropriation processes of a newly developing subworld, have more to gain from

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<sup>41</sup> Dr 21.

distancing themselves and their clinical practice from the non-medically qualified than from being seen by others within their professional community to be participating in networks with members of other medicines.

In addition to the claim that lay diagnosis is dangerous and the contrasting portrayal of the GP's diagnosis as offering safety and protection to the patient, some GPs offer another presentation of risk associated with unconventional treatments. Some GPs explain lay therapy as involving direct adverse effects; that is, they highlight what they see as the 'direct physiological or physical impact from the intervention itself' upon the patient.<sup>43</sup> Here again we have an appeal to the safety of a medical approach to the therapies, one where medical science and conventional procedures are perceived as *essential foundations* to good therapy. As Dr 11 outlines one justification for his use of acupuncture in general practice:

I think the safety of it, the safety of being medical and using something like needles, you know, there are a few points around where you are dicing with death, you can sort of puncture someone's lung if you put it in the wrong place and that sort of thing so there's the odd thing like that where I think my medical training and knowledge of anatomy and everything else like that is better.<sup>44</sup>

The following GP similarly explains what she sees as the dangers of lay hypnotherapy:

I think the non-medically qualifieds can do a lot of harm and they quite often do. They can implant post hypnotic suggestions, you can suggest to someone that when they come out of a trance something might happen and usually it

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<sup>42</sup> For example Reilly, D. (1983). 'Young Doctors' Views on Alternative Medicine'. *British Medical Journal* 287: 337-339. In addition, the data collected from the questionnaire component of this study indicated a similar trend amongst GPs in the cities of Edinburgh and Glasgow.

<sup>43</sup> This is based upon Jonas, W. B. (1996). *Op. Cit. No. 26*. p.130. These concerns are mirrored in recent medical literature assessments whereby those established in medical complementary medicine have attempted to assess the direct risks of complementary practice. As one medical commentator claims to equate complementary therapies with 'harmless is at least misleading, at worse it is dangerously wrong'. Ernst, E. (1996). *Op. Cit. No. 26*. p.112.

<sup>44</sup> Dr 11.

will or they behave in a certain way and they can implant ideas in people and they actually make them quite disturbed.<sup>45</sup>

Dr 15 employs a similar theme in the attempt to discredit non-GP homeopathy. The GP opens this section of talk by emphasising the potential side-effects of homeopathic remedies:

I've had people come back and tell me all sorts of things, all sorts of side-effects which I've not known or understood in any shape or form but you get people want to know the side-effects from them, they're not innocuous because people will get side-effects from them. I've one lady that I wonder. She wasn't a patient of mine but she died of urethra carcinoma and I think homeopathy was used inappropriately for her because she was so keen to have it used and I think it was quite, you know her death happened in a way that homeopathy might have been implicated certainly her using homeopathy blocked her opportunity of using other things that she might have lived from or lived considerably longer and this was a very untimely death in a relatively young lady who would have died anyway but maybe two years down the line. That was my insight, my anxiety about them [complementary therapies] is that people would use them inappropriately and not avail themselves of other medication but that's my training firstly as an allopathic doctor.<sup>46</sup>

This doctor highlights the theme of safety with direct reference to his conventional training. In this quote he emphasises the dangers of relying too strongly on only one form of medicine. As a later section illustrates, many of the GPs employ similar rhetorical tools in an attempt to discredit lay therapy as narrow and imbalanced.

One GP practising acupuncture remarks, 'oh I think [conventional diagnosis] is important. I think that there's a danger once you start to treat somebody with acupuncture that you don't actually deal with other things that arise or any changes in the condition and things can get missed, so obviously it's important giving an accurate diagnosis first'.<sup>47</sup> This quote, and many of those outlined in the course of this section, illustrate the use of another specific set of discursive tools with which all the GPs

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<sup>45</sup> Dr 16.

<sup>46</sup> Dr 15.

demarcate non-medical practice from that of themselves and fellow GPs practising unconventional therapies. Flowing throughout all of the GPs' accounts, especially in relation to their description and understanding of lay therapists, is an appeal to the imagery of openness and flexibility in relation to their own practice and in contrast a classification of lay therapy as fixed, rigid and unduly restrictive in character. As will be explained in the following section, as with the discourse of safety and the attention to conventional diagnosis these rhetorics also hinge upon and further emphasise the distinction and advantages of *complementary* practice as opposed to what the doctors term *alternative* practice.

#### **4.2.3 Rhetorics of Scope: Restrictive Alternatives and Expansive**

##### **Complementaries**

You can use [acupuncture] as an adjunct to all sorts of other therapies. What I mean is if I'm an acupuncturist solo, that's my job private outside, all I can do is treat people with acupuncture. Here I can practise, I can treat people with normal medicine, I can refer them to a homeopath, I can refer them to various, physiotherapy, but I have this added, er, arrow in my quill which I can use for acupuncture.<sup>48</sup>

To briefly return to the theme of diagnostics as found within the GPs' accounts, we can identify what I here term the rhetorics of 'scope' and their importance in creating and maintaining the discursive boundary between medical and non-medical practice. The following extract from an interview with a GP practising hypnotherapy provides a clear example of the imagery of rigidity and inflexibility when describing the procedures of lay diagnostics, and illustrates the role of that imagery in the boundary work which demarcates lay practice from that of general practitioners. She claims: 'one of the things about lay people...is that doctors are

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<sup>47</sup> Dr 23.

trained from early on to have differential diagnoses and be prepared to change our diagnosis and lay people seem to be often very *fixed* in their ideas'.<sup>49</sup> She later exemplifies what she sees as the fixed position of lay therapists:

one of the things that's well known to happen and well documented is that, it is said that very obese people have been sexually abused. Now that can happen because a woman whose been sexually abused will over eat to keep herself fat, she's unattractive to men, it won't happen again. Now the lay people, some lay therapists, get this *fixed* idea that that every person who is overweight has been sexually abused, that must be what's wrong with them - certain ones get *very fixed ideas*. Now somebody comes in and they're very thirsty and eat, eating lots of sweets all the time and you think are they diabetic? but you test to find if they've got sugar in their urine, not everybody who's thirsty is a diabetic, its that sort of idea, and they've never had the training in making a diagnosis.<sup>50</sup>

These rhetorical devices of flexibility and rigidity are equally employed with regard to the overall practice of the two different groups of practitioners. On the one hand lay practice is described as characteristically 'rigid', 'closed' or 'narrow' while a pivotal defining feature of general practice is understood to be the GP's flexibility, rounded approach and awareness of possible alternative avenues to treatment. With regard to lay therapists one GP acupuncturist recollects his experience of a lay therapist with whom he once combined efforts to treat a patient:

she's a lay acupuncturist and she's erm, very much more towards the treat everything with acupuncture and don't take any drugs side of the argument

Interviewer: And how do you feel about that?

Well, I'm happy to accept that, that's her view and that's fine. I had a patient who was seeing us both, who was seeing me for other treatment and she was seeing her for acupuncture and there was a bit of conflict there because she was very much of the opinion that the patient probably didn't need drugs in addition to the acupuncture. I was quite happy to accept both but the acupuncturist wanted to, wanted just the acupuncture and there was a bit of conflict there.<sup>51</sup>

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<sup>48</sup> Dr 2.

<sup>49</sup> Dr 5.

<sup>50</sup> Dr 5.

<sup>51</sup> Dr 19.



This quote illustrates how the two positions - lay therapy on the one hand and general practice-based therapy on the other - can be presented quite explicitly as in opposition and conflict. In the particular extract of talk above, the GP portrays himself as the compromising party in the argument between the different practitioners: he is 'quite happy to accept both' treatments, and he is 'happy to accept' her position, 'that's her view and that's fine'. Meanwhile, the lay therapist is described in more forcefully rigid terms as 'wanting *just* the acupuncture'. A similar perception is suggested by many GPs practising homeopathy in their understanding of lay homeopaths and the particular issue of prescribing and approving conventional medications alongside homeopathic remedies.<sup>52</sup> As one GP homeopath claimed of lay therapy, 'it's blinkers on, you know, don't use any other medication, it's homeopathy alone'.<sup>53</sup> Another outlines the rigidity and dangers of lay homeopaths in the following terms:

Well I think a lot of lay homeopaths would be very anti-standard medicine...you can't use steroids, you can't use immunisations...some homeopaths would think that's destroying your immune system and, you know, they would never give steroids - if you give steroid creams that drives the illness inside and everything has to heal from above down and from in out.<sup>54</sup>

Another GP explains a similar rigidity but in this example he refers to patients that he has treated who have adopted the approach of the lay practitioner to homeopathy:<sup>55</sup>

there are patients that I've come across, occasional patients who have wanted to stop what to me was life enhancing medicine, you know, heart failure, stuff of that sort and it is certainly difficult to go along with at the end of the day if I'm able to respect the person and their decision I have to do that and not

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<sup>52</sup> This theme of combined practice is explored in more depth in chapter five where the GPs' constructions of clinical realities are outlined.

<sup>53</sup> Dr 20.

<sup>54</sup> Dr 12.

<sup>55</sup> Here we have what would seem to be an ultimate appeal to the notion of the lay practitioner: the boundaries between non-medical practitioner and certain sections of the public are deflated in this quote. In this sense, lay therapists are hereby portrayed in a sense as synonymous to those without qualifications and training of any description.

withdraw myself from supporting them, er, it creates difficulties for me if the two medicines are perceived as being irreconcilable to each other, I don't see it.<sup>56</sup>

Here again we can identify the suggestion by the doctor of the medic shifting approach slightly and accommodating the rigid lay homeopath: while faced with a patient who perceives the homeopathy in a way that he 'doesn't see' he nevertheless maintains his support and responsibility for the patient to the best of his abilities.

A number of the doctors present alternative therapists as unwilling to complement their therapy with other medicines; they are characterised as exclusively tied to their own mode of therapeutics and as 'closed' in their thinking and outlook. In contrast, general practice is characterised as open and flexible. As one GP acupuncturist perceives his practice, 'I explore an avenue. I don't have to approach it with any basic fundamental assumptions. I don't have to stick to a particular way it works'.<sup>57</sup> Another GP referring to her integrative practice suggests that 'the two things [conventional and complementary medicine] are not in any way in opposition but that it's sometimes that the one may be more important than the other'.<sup>58</sup> In some of the accounts the denial of lay practitioners of the possibility of other courses of medical treatment is seen as producing a 'lop-sided' approach while general practice is seen as helping provide 'a much more balanced approach' to the therapies.<sup>59</sup>

There is a constant play within many accounts upon the imagery of 'exclusive dependency',<sup>60</sup> of the non-medically qualified upon single medicines: they are practising the therapies 'in solo' and they think their therapy 'is everything'.<sup>61</sup> As the

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<sup>56</sup> Dr 15.

<sup>57</sup> Dr 19.

<sup>58</sup> Dr 13.

<sup>59</sup> Dr 20.

<sup>60</sup> Dr 12.

<sup>61</sup> Dr 22.

following extract reveals this is expressed by some GPs in terms of a refusal by lay therapists to pass patients on to practitioners of other medicines even after treatment has been ineffective:

a medical complementary therapist will say right this is an acute abdomen this will have to go into hospital, I'm not going to give it Belladonna. Whereas a lay practitioner might very well say well if Belladonna doesn't work I'll try another homeopathic remedy, you know whereas, I think you're safer seeing a medical person'.<sup>62</sup>

Again this particular extract from a GP's account suggests a fear of the inability of lay therapists to successfully diagnose certain conditions. In response it is claimed by this GP that some lay therapists may slavishly pursue their alternative line of treatment when serious illness may require the specialised intervention of other courses of treatment available only within hospital medicine.

A GP explaining her stance on such an approach echoes the sentiments of many of these doctors when she says, 'I would criticise just as much people who are *only* into homeopathy'.<sup>63</sup> This GP draws upon the contrasting imagery of openness and rigidity as a means of explaining this position, when she later adds:

that's a *closed mind set* as well. It's just a different sort of closed mind. I really think you have to *open up* your mind and say OK I've got twenty skills here and I'm gonna access one, two, three of them all this morning right and that's the way I would see this almost like a group of things that I can access at any time I like and *I'm not frightened* to go and access them.<sup>64</sup>

This GP draws upon notions of the generalist as a means of contrasting her practice from that of lay therapists.<sup>65</sup> And as she further explains: 'it's a skills thing...I see myself as multi-skilled and people would call that a jack of all trades and a master of

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<sup>62</sup> Dr 3. Dr 15 also highlights this rigidity and its possible dangers. He says, 'the danger or the non-safety of them would be if they're used in a blinkered way. I mean they're not appropriate for everyone'.

<sup>63</sup> Dr 14.

<sup>64</sup> Dr 14.

none'.<sup>66</sup> Dr 11, practising both acupuncture and homeopathy, outlines what he sees as an advantage of his development of acupuncture within general practice: 'there's the fact that I can combine it or GPs can combine it with all the other treatments where maybe an acupuncturist just homes straight in on acupuncture'.<sup>67</sup> Dr 11 also talks of a range of skills, available to GPs and inaccessible to lay practitioners: 'I would say that's probably a doctor's *band of skills*, I mean you can perhaps choose the right time to use it and the right time not to use it'.<sup>68</sup> This extract from the GP's account also highlights how this appeal to the extensive skills and 'rounded' approach of general practice provides a link to the claim that complementary therapies require a conventional diagnosis and that lay therapists have a limited scope of practice when seen in these terms. The following quote from Dr 10 clearly illustrates how these GPs draw upon the imagery of openness and flexibility as a means of explaining their practice. He explains, 'I've never liked to be closed to anything. I've always liked to, you know, if something new comes along I always like to know about it...so I wouldn't like to be feeling that homeopathy was all there was'.<sup>69</sup>

There is an appeal within the accounts to an understanding of lay therapists as too adventurous in practice and as having too high expectations of their therapy's power to heal; an expectancy that in some cases is perceived as born out of the therapists' dependency on one specialist therapy. The non-medically qualified are seen as 'heroic' in their approach, they are convinced of the omnipotent powers of their system of medicine and, as a result, often persist in treatment when this is clearly

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<sup>65</sup> The issue of generalism and specialism is a theme which is more fully explored later in this chapter. It is also the basis of similar rhetorical constructions made by the GPs in relation to the professional boundaries between hospital medicine and general practice as examined in chapter six.

<sup>66</sup> Dr 14.

<sup>67</sup> Dr 11.

<sup>68</sup> Dr 11.

<sup>69</sup> Dr 10.

unsuitable. One GP practising homeopathy and acupuncture describes a concern with lay homeopaths and their approach to homeopathy:

a lot of homeopaths think there's a remedy for every ill, you can cure everything, or every ill needs to have a remedy and it doesn't you know. People get ill and they get over their illness, the vast majority of them if they're healthy, have a good diet, they'll just get over it so you know every time you get a cold doesn't mean you've to rush off and get a homeopathic remedy, but a lot of the homeopaths are like that, all of but taking this remedy I wouldn't have got better, but you know a lot of illnesses are self-limiting and trivial and there's no point in taking a pill for every ill and that's one thing I don't like about them, the alternative therapists, you know, there's supposed to be a pill for every ill, you know, there shouldn't be a pill for every ill.<sup>70</sup>

In this quote above GP 12 presents the approach of alternative therapists as encouraging overuse and dependency amongst patients upon homeopathic remedies; even patients with self-limiting and trivial medical problems are encouraged to seek homeopathic treatment. As will be seen a little later in this chapter the rhetoric of dependency is a powerful device which is used by some GPs to justify the relocation of unconventional therapy away from the private non-medical sector to the general practice setting.

In the accounts there is a notion of lay therapy as a 'purist' form of treatment; a purity that is not beneficial but detrimental to the overall welfare of the patient. A 'pure' or 'traditional' approach to unconventional treatment, associated in the accounts with the non-medically qualified, is presented as uncompromising, unduly harsh and unrealistic. To quote GP 3:

I think born again homeopaths would say oh you can't drink tea or coffee when you're taking medicines which are made with plant extracts and things like this. How far are you prepared to go? I mean I see people on horrific diets that they've been put on by these herbalists. Yes their arthritis is getting better but my god their life is limited, they might have been better taking my nonsteroidals than going on these crazy diets.<sup>71</sup>

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<sup>70</sup> Dr 12.

Here the doctor describes how the alternative approach to homeopathy can be uncompromising for the patient: while the condition may improve it is suggested that the short term gains may effectively be neutralised in terms of the patient's subsequent standard of life. Here there is a suggestion that while prevention and self-help may be *one* objective of care, there is a danger that too much surveillance and involvement in the patient's lifestyle may be detrimental.

Related to this presentation in many of the accounts of the non-medical approach as pure and unrealistic is reference to underlying philosophical and theoretical assumptions and their relationship to therapeutic practice. Lay therapy is portrayed as committed to distinct alternative systems or models of medical knowledge, ontologies and epistemologies. Meanwhile the general practitioners characterise themselves as pragmatic in their approach to the therapies taking only those elements of philosophies and theoretical models that they feel comfortable with or that are deemed sensible and realistic. Lay therapists are seen as dogmatically following theoretical and philosophical models as a guide to practice while general practitioners describe their own practice of the therapies as 'practical', 'ad hoc' and as a 'traditionally-based pragmatic approach'.<sup>72</sup> As one GP practising hypnotherapy and homeopathy describes her use of unconventional therapies, 'my main use of them is, what you call it, *in practice*'.<sup>73</sup> There is also a suggestion by one or two GPs, which links with this notion of practicality and the GPs' insistence that the therapies be combined with conventional treatments, that the 'pure' approach taken by lay therapists renders their practice out of touch with the real world. As one GP claims, 'I think in a nutshell we live in an imperfect world and I don't think there's a perfect

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<sup>71</sup> Dr 3.

<sup>72</sup> Doctors 2, 9 and 14 amongst others employ such terms.



system, yeah, so I think that's, I don't know we'll never find a perfect system of medicine and I think we probably have to choose between systems'.<sup>74</sup> Dr 10 outlines what he sees as the difference between a restrictive alternative approach and a complementary approach which appreciates the benefits of both types of medicine. He states:

I think reflexology could quite easily be restrictive in a way that, osteopathy less so, but chiropractic can be a bit restrictive in that really all the ills of the body are not arising from some malign of the spine, there is more to life and I feel that reflexology is closer to that type of restrictive practice than the acupuncture because the acupuncture, they've got more entire, they're not exclusive you know. You can have a bit of each. It's not because you're having acupuncture you can't have the rest because I don't like things that sort of shut out the rest and reflexology does that a little bit.<sup>75</sup>

Interestingly, this quote also illustrates how a few of the GPs demarcate between the different therapies available. The GP talks of reflexology and some other therapies as inherently restrictive while acupuncture is less of an exclusive medicine. In these terms, it would seem that certain therapies are not only perceived by this GP as alternative when practised outside the primary care setting but are alternative in nature (rather than in style) and as such are inappropriate therapies for use in general practice.<sup>76</sup>

Another GP explains his understanding of lay homeopaths and what he perceives as their dedication to a 'pure' form of homeopathy that proclaims the medicine cannot be mixed or integrated with orthodox medical treatments. Again, there is a suggestion that 'pure' homeopathy is out of touch. The GP says:

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<sup>73</sup> Dr 14.

<sup>74</sup> Dr 20.

<sup>75</sup> Dr 10.

<sup>76</sup> This is a construction outlined in the BMA report of 1993. The report states, 'there are some therapies which, by their very nature, aim to replace orthodox medicine', BMA (1993). *Op. Cit.* No. 3. p.7.

that's back to Hahnemann's sort of, you know, whatever Hahnemann said is true and that's you know things have progressed in three hundred years you know you just don't get these healers that know everything, you know, that's just *not how the world is*. I think you know you just have to be *practical* about these things.<sup>77</sup>

Here the GP also draws upon a potent rhetorical construction that is prominent in a number of the GPs' accounts. He distinguishes lay practice as based upon an outdated, pre-modern or non-progressive approach to medicine and healing. There would appear to be an accusation embedded in this talk that scientific progress and the advances of medical science and associated technologies have rendered the 'purist' form of homeopathy - rooted in the writings and teachings of Hahnemann - redundant. Another GP homeopath makes similar appeals in relation to the same theme, provoking imagery of classical therapy and the transformation of conventional medicine over the last century up to the present form today. He claims:

this is the classic thing: you can't use conventional treatment along with homeopathic treatment. Now that was the dictum or the dictate I should say before the twentieth century when conventional medicine included such things as bloodletting, cupping and that sort of thing, sort of manner of horrific stuffs that people made up so it's not exactly the same as conventional medicine as we know it today.<sup>78</sup>

This talk suggests that homeopathy was founded at a time when horrific treatments were the norm in conventional practice, thereby promoting a conception of 'pure' homeopathy (which is perceived as still associated with this early founding work) as itself horrific in its extremity. This talk also helps project modern day conventional medicine as relatively safe and progressive in the sense of highlighting its transformation over the last century away from 'horrific stuffs'.

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<sup>77</sup> Dr 12.

<sup>78</sup> Dr 8.

Staying with GPs' views of homeopathy, one GP explains such transformations from rigidity to flexibility in relation to homeopathic training and courses held at the homeopathic hospital in Glasgow. She says:

I get the impression that I think homeopathy's changing. For example, the first day of the first course I went to, no the second day they asked us what we'd been using and one of the students had said how they'd used [a homeopathic remedy] and the lady had taken away 30c tablets in a bottle and she'd been told to just use it whenever she felt a panic attack and there was a woman who was also a *classical* homeopathist, homeopathly homeopath, who got up and was very angry that this was not *classical homeopathy*, this was not what she'd come here for and she stormed out and I think over the five years our lectures, the actual lectures themselves have changed slightly, and in the first year there was still a lot of the *traditional classical homeopaths* lecturing. I think now we're seeing more of the medically trained.<sup>79</sup>

This GP homeopath above explains how she perceives homeopathy itself, understood as a therapeutic community of practitioners, to be changing in approach. Again in this extract of the GP's account appeals are made to the classical and modern styles of therapy.

As part of the presentation of general practice as a 'rounded' and 'flexible' style of practice some GPs refer to a number of features of general practice which are used to highlight the benefits of integrative practice - benefits which lay therapists (who are not trained in conventional medicine) do not have at their disposal. These include access to such things as x-rays, an array of different diagnostic tests, and the medical services of specialists in the case of referrals. As one GP acupuncturist explains what he sees as a problem of lay therapy: 'are they able to offer the same universal family service that a GP can offer? I mean, I think there are many things that they can't treat, er, there are so many things that you can't treat as an acupuncturist'.<sup>80</sup>

Dr 5 who practises homeopathy, hypnotherapy and neurolinguistic programming

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<sup>79</sup> Dr 7.

highlights what she sees as the difficulties facing lay therapists in terms of extending treatment to other specialists through referrals. She says:

the other thing about lay therapists is who do they refer to? and you see to me we want to find out what a patient's allergies are and we refer them and the diagnosis made might be irritable bowel syndrome. So would the lay therapist have accepted that diagnosis and gone down that line? Now, doctors will refer to a colleague - can you give me help? - how do lay therapists refer to doctors?<sup>81</sup>.

Interestingly, previous research has suggested that lay therapists themselves are aware of and concerned by the issue of referrals between 'alternative' therapists. Some would appear to perceive their opportunities for referral for second opinions as inadequate and cross-communication between therapists as poorly developed.<sup>82</sup> However, there has been a suggestion that group practice is as popular among non-medical therapists as among GPs,<sup>83</sup> and despite the vast differences across the spectrum of unconventional medicine, these circumstances may at least provide a wider opportunity for 'alternative' referrals between the practitioners of different therapies.

Another GP practising acupuncture also talks of certain practice facilities and features which are not available to lay therapists:

Well they don't have access for erm, routine investigations. They don't have access to x-rays, they don't have access to patient records and they don't have access to an assessment by a general practitioner who's known them for a long time.<sup>84</sup>

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<sup>80</sup> Dr 4.

<sup>81</sup> Dr 5.

<sup>82</sup> Cant, S. and Calnan, M. (1990). 'On the Margins of the Medical Marketplace? An Exploratory Study of Alternative Practitioners' Perceptions'. *Sociology of Health and Illness* 13(1): 39-57. p.43.

<sup>83</sup> Sharma, U. (1992). *Op. Cit. No. 3*. p.93.

<sup>84</sup> Dr 2.

In addition, Dr 13 developing homeopathy and hypnotherapy in her practice echoes similar rhetorical presentations as a means of justifying and appropriating her use of the therapies. She claims:

I'm sure it's much better if it's done in the practice here because you've got a whole picture of not just the person but the family, their situation, you've seen them in an ongoing sort of way...I'm sure to do it in a primary care setting would have much bigger benefits.<sup>85</sup>

From these last two quotes we can detect, amongst other things, how the GPs draw upon a number of related rhetorics ( including community and family-based care and continuity of care) as a means of not only claiming worth for general practice complementary therapy but also to deauthenticate and undermine lay therapy. These are discursive devices which run through many of the different GPs' justifications for developing integrative practice.<sup>86</sup> The GPs portray themselves and their primary care colleagues as the health professionals *in* the community: they are the doctors able to provide adequate continuity of care and as such already know the patient prior to initiating complementary therapy. As Dr 1 justifies his integrative practice, 'general practice is the place where people come if they've got what they perceive to be a problem with their health...so, you know, that's the reason *par excellence*'.<sup>87</sup> In contrast, lay therapists are described as removed and detached from the community setting and from the benefits this entails. The following extract from the talk of Dr 11 clearly illustrates the use of this contrasting rhetorical imagery:

[alternative therapists] don't have the medical records. I mean we're sitting here with medical records about the patient and know exactly the operations

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<sup>85</sup> Dr 13.

<sup>86</sup> Here we can see how the different ideological tasks of these accounts are often interwoven. Such claims accomplish the following tasks simultaneously: First, they help undermine lay therapy and distance such therapy from complementary practice developed in primary care; second, they help appropriate unconventional medicines to the general practice setting (processes examined in more detail in chapter five).

<sup>87</sup> Dr 1. This quote also links closely to the discourse of access which is employed by most of the GPs to criticise lay therapy and is discussed more fully later in this chapter.

they've had, you know, and what happened to them twenty years ago, their family history and you know at the beginning of our notes we have this page where we automatically open to that and you glance and you know the cot death that happened twenty years ago but oh funnily enough it was the same dates as they've just come in. I don't think maybe alternative people necessarily have that information.<sup>88</sup>

As this quote reveals there is a claim in some of these accounts that being the GP *in* the community promotes a deeper understanding of and closeness to patients. More generally too, as the next section illustrates, the discourse of community also interweaves with another set of closely related rhetorics whereby the GPs demarcate themselves from lay therapists and attempt to deauthenticate these practitioners of other medicines.

#### **4.2.4 Bringing the Therapies Back Home**

##### **4.2.4.1 Contrasting Cultures and Medical Languages**

Some of the GPs expand the notion of community-based practice to a wider cultural level. Here they present the two styles of practice - complementary and alternative - as representing two cultural types or as being grounded in two opposing cultures. Moreover, complementary practice, and conventional practice more generally, are located at the core of modern Western culture while alternative practice is constructed in terms of cultural marginality.<sup>89</sup> The idea that unconventional

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<sup>88</sup> Dr 11.

<sup>89</sup> Cultural marginality is also identified within some earlier social science literature through the use of the terms 'marginal' or 'fringe' to classify the therapies. See Wallis, R. and Morley, P. (1976). *Marginal Medicine*. London, Peter Owen. As one commentator has since reflected upon this use of such titles, 'meant in a kindly way by those who coined the term - it was around the time of the Edinburgh Fringe - the association with 'lunatic fringe' was perhaps a little too close for comfort'. West, R. (1992). 'Alternative Medicine: Prospects and Speculations'. In Saks, M. (ed.) (1992). *Op. Cit.* No. 3. Furthermore, these titles were chiefly employed in the late 1960s and early 1970s and this rhetorical construction does seem to run in the face of what has been quite unequivocally established as an overwhelming increase in interest and use of these therapies by patients in Britain over the last fifteen to twenty years. Interestingly, one social scientist has suggested that orthodox medicine may find itself nearer the margins of British culture in the not too distant future. She states, 'By the end of this century usage of non-orthodox medicine of some kind may well be a majority experience. The



medicines represent an exotic other which is removed from Western culture has been popular in many circles and as Sharma has argued, 'the contextualisation of alternative medicine with the *exotic*...is something western healers have endorsed themselves, and which some purveyors of alternative remedies have positively promoted'.<sup>90</sup>

Again, as elsewhere in the accounts, the GP therapists highlight the philosophical and theoretical foundations of 'alternative' therapy as a means of demarcating the two styles of practice. Alternative medical knowledge, which is associated with lay therapy within the accounts, is perceived as operationalising unfounded concepts and mumbo-jumbo language. This presentation is stressed by the GPs as a prime example of the non-medically qualifieds practitioners' location outwith mainstream culture and public understanding. There is talk of how '[lay homeopaths] get into the whole philosophy of homeopathic medicine',<sup>91</sup> how they are in a particular 'mind set',<sup>92</sup> and how for them 'it's a whole cultural thing'.<sup>93</sup> Likewise, some GP acupuncturists classify lay acupuncture as 'traditional Chinese medicine', disconnected from the West, detached from Western understandings of the world and contrasting with the 'standard Western approach' to acupuncture employed by the GPs themselves. As one GP acupuncturist explains his understanding of 'traditional' acupuncture and what he sees as his relationship to this approach in terms of his own practice:

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implication of this is that if orthodox medicine retains its status as the form of medicine authorised by the state in most western countries, it will continue to be orthodox in the narrow political sense but may no longer be orthodox in the cultural sense of being the form in which the public at large has the most confidence and regards as the most legitimate'. Sharma, U. (1992). *Op. Cit. No. 3*. p.26.

<sup>90</sup> Sharma, U. (1993). 'Contextualising Alternative Medicine'. *Anthropology Today* 9(4): 15-18. pp.15-16.

<sup>91</sup> Dr 12.

<sup>92</sup> Dr 6.

<sup>93</sup> Dr 24.

I think traditional Chinese acupuncture comes from a completely different religious and philosophical base, er, it's tied up with religion, er it's a spiritual existence in China. I mean none of these things I was brought up with or I really understand...its integrated and tied up very closely into the Chinese way of looking at things.<sup>94</sup>

And he goes on to expand this claim by saying:

I'd find [traditional acupuncture] impossible to accept as a Western doctor, er but this is a *different culture* and *with different beliefs*, so you know you respect it within that culture but I can't use it, I can't use it in any constructive way you know working as a doctor in the West.<sup>95</sup>

Again we can see how these GPs' claims ( in this case regarding *home* culture and *other* culture) enhance a conventional medical approach as an appropriate tool with which to appropriate and contextualise the practice of these therapies.

A number of the GPs employ the rhetorical device of contrasting languages alongside their appeal to the different cultures underlying lay practice and their own 'complementary' therapy within the boundaries of general practice. They link images of an 'alternative' medical language to lay therapists' support of 'alternative' medical and philosophical models and, as will be illustrated shortly, describe such language as in need of translation for it to be legitimate. Lay practitioners' therapeutics are seen as couched in 'mumbo-jumbo' concepts and understandings. As one GP explained with regard to such concepts as yin and yang and the vital energy of the patient: 'I think doctors probably never use that type of language because they are doctors and they are just working in the field'.<sup>96</sup> Comparable discursive constructions are also employed in more formal medical literature relating to unconventional therapies. The BMA report of 1993 uses similar language in its assessment of the different therapies.<sup>97</sup>

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<sup>94</sup> Dr 4.

<sup>95</sup> Dr 4.

<sup>96</sup> Dr 5.

<sup>97</sup> BMA (1993). *Op. Cit. No. 4*. The report states, 'in the clinical practices of osteopathy and chiropractic, the basic training is largely grounded in the orthodox medical sciences and, as such,

Furthermore, much of the medical literature centred around developing multidisciplinary care teams and other forms of co-operation between alternative therapists and general practitioners has consistently portrayed different clinical languages as a potential obstacle to good effective collaborative practice.<sup>98</sup> What separates this field of literature from the talk of these GPs is that while the former suggests that 'alternative' medical language may be given equal weight in clinical decision making (even if this is only lip-service), these GP therapists construe such language as inferior and ultimately as illegitimate.

#### 4.2.4.2 Alternative Therapists as Extremists, Secretive and Out of Touch

Concurrent with this attention to the languages of the different styles of medicine and the positioning of lay therapy on the cultural margins is the use by many of the doctors of such terms as 'fanatical', 'extremist', 'fundamentalist' in their descriptions of a range of lay therapists. There is talk of 'born again homeopaths' and one GP describes lay therapists as comparable to a 'religious cult'.<sup>99</sup> Consistent with this perception, another GP who practices homeopathy, acupuncture and hypnotherapy explains his orientation to homeopathy in the following way: 'homeopathy was never a religion with me, the way it is for a number of people who only, who are exclusively using homeopathic remedies'.<sup>100</sup> This same GP later adds, 'I actually think quite a lot of homeopathy is *alternative* because there are some real *fanatics* practising

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practitioners of these disciplines are able to have a close dialogue with their medical colleagues which is based upon a *common language*.' p.6.

<sup>98</sup> Peters, D. (1994). 'Sharing Responsibility for Patient Care'. In S. Budd and U. Sharma (eds). *The Healing Bond: The Patient-Practitioner Relationship and Therapeutic Responsibility*. London, Routledge. Reason, P. *et al.* (1992). 'Towards a Clinical Framework for Collaboration Between General and Complementary Practitioners: Discussion Paper'. *Journal of the Royal Society of Medicine* 85: 161-164. Pietroni, P. C. (1991). 'The Reflective Practitioner'. *Journal of Interprofessional Care* 6(1): 7-16. As Pietroni (above) suggests, 'it is as yet unclear whether...we shall need to become multilingual or develop a common language'. p.7.

<sup>99</sup> Dr 12.

homeopathy very much to the exclusion of allopathic medicine - that's outside general practice'.<sup>101</sup> These images of extremism are employed by the GPs in a number of ways: to describe the therapists' approach to treatment; to ridicule their insistence upon the use of alternative medical knowledge and philosophy as the basis of therapy; and to point up what is seen as their unrelenting allegiance to unconventional treatments for unsuitable medical complaints. Furthermore, some GPs also draw upon the imagery of new age or hippie culture as a means of discrediting lay practitioners and presenting them as 'alternative'. The following GP draws quite blatantly upon these rhetorical constructions when he describes why he sees his use of complementary medicine to be credible and how this is in contrast to lay practice:

Put it this way - if you think that your GP thinks that its a useful technique then you'll tend to have a bit more faith in it than if you weren't sure or you said oh my pal went there and it was good. Lots of people are quite prepared to be disappointed in complementary medicine outside but I think they've got other expectations if a GP's using complementary medicine unless I come in here wearing an ethnic skirt and stuff like that, you know, they might, you know what I'm getting at ... If I was the sort of GP who had long hair and wore you know sneakers and jeans and had a beard and things like that, you know, flower power sort of stuff.<sup>102</sup>

Evoking similar imagery, some of the GPs explain how they perceive lay therapists and their practice to be secretive. The following GP explains her experiences of encountering patients who have previously consulted lay homeopaths: 'I'm always interested in what people prescribe but homeopaths are very secretive about what they prescribe, maybe they don't think that anyone else will understand it'.<sup>103</sup> In similar terms, Dr 22 outlines one point that she sees as demarcating lay therapy and general complementary practice. She refers specifically to one patient

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<sup>100</sup> Dr 10.

<sup>101</sup> Dr 10.

<sup>102</sup> Dr 17.

<sup>103</sup> Dr 21.

who had previously seen a lay homeopath before consulting her: 'the only difference was that he was given a remedy and not told what it was. For some reason this was kept secret from him and he was charged a vast amount of money to buy something'.<sup>104</sup> Some GPs link this secrecy directly to the alternative or 'mumbo jumbo' language and explanations that they associate with lay practice. As one GP acupuncturist describes his perceptions of lay therapy, 'I think there's probably less explanation of what's going on. I imagine that people do tend to pump up the mysticism side of it'.<sup>105</sup>

#### **4.2.4.3 Claiming a Role for the General Practitioner in Unconventional Medical Care**

All the different yet interrelated interpretative repertoires which are used by these GPs in their descriptions of lay therapists and their practice - including notions of rigidity, marginal cultural status, incomprehensible medical language and knowledge, secrecy, and fanatical and extremist approaches to practice - help promote an impression of non-medical therapy as inaccessible, isolated and thereby in need of revision. This links to a number of popular justifications GPs offer for their own use of these therapies. These constructions can be seen as an attempt not only to discredit lay therapy but also as a means of justifying the practice of unconventional therapies within GPs' own surgeries. Many of the GPs present themselves as occupying a social and a moral role with regard to unconventional therapies. These arguments can be broken down into two distinct yet related themes: protecting the public from lay practitioners; and translating alternative medicine making it digestible for patients.

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<sup>104</sup> Dr 22.

<sup>105</sup> Dr 19.

## 4.2.5 Protecting and Regulating Against Extreme Practitioners

Some GPs project themselves as protectors of the public; they perceive themselves as shielding patients from the potential dangers of ‘fanatical’ alternative practitioners. As Dr 21 explains, ‘I need to educate myself in order to protect patients from the more extreme practitioners’.<sup>106</sup> This protective role involves guarding the public from the direct and indirect dangers of lay practice, as detailed earlier. But protection also refers to more than just the dangers involved in the clinical application of unconventional therapies.

### 4.2.5.1 Lay Practice as Under-Regulated

There is an appeal within the GPs accounts’ to the market circumstances within which lay practice is conducted, and more specifically, to what the GPs portray as a sector of health care provision that is both under-regulated and under-monitored. As a result of this situation the GPs portray the training and qualifications of some lay therapists as inadequate or simply non-existent. Meanwhile, studies have highlighted the opposing claims of lay therapists.<sup>107</sup> For example, Sharma suggests from her small scale qualitative study of non-medical therapists that ‘lay homeopaths...claim that their training gives them a better grounding in the principles of homeopathy than the much shorter courses offered by the Faculty of Homeopathy’.<sup>108</sup>

It is indeed the case that anyone can set up practice in Britain, offering their services to a paying public and using the title of therapist. Some GPs highlight this situation to ideological affect: ‘there are still some people in this area still practising

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<sup>106</sup> Dr 21.

<sup>107</sup> Sharma, U. (1992). *Op. Cit. No. 3*. Cant, S. and Calnan, M. (1991). *Op. Cit. No. 82*.

<sup>108</sup> Sharma, U. (1992). *Op. Cit. No. 3*. p.185.



homeopathy who've no qualifications at all and that worries me a lot';<sup>109</sup> 'anyone can set up as an acupuncturist and people can take advantage of others in these sort of circumstances';<sup>110</sup> and as another GP describes the lay sector, 'my concern about alternative medicine is that it has to be properly regulated and I know there are lots of cowboys out there who don't have sufficient training who are giving alternative therapies a bad reputation'.<sup>111</sup> GP 14 draws upon these themes to describe the private lay sector:

I'm not aware of there being very good exams and accreditations whereby one could generally say well this person has been through the mill and as far as I'm aware with these things you can just stick a notice up upon your door and claim you're that and get on with it.<sup>112</sup>

Another of the GPs also talks of the possible dangers which he perceives as associated with lay provision:

my worry with some complementary therapies is that if they are not properly, if maybe the practitioners aren't properly accredited or if there isn't a proper system of control that they could end up doing damage to people. I mean I've heard of some complementary therapies like Chinese Medical Herbalism or people who call themselves Chinese Medical Herbalists who can treat people with what are apparently benign Chinese Medical Herbs which on further investigation turn out to be fairly toxic doses of Western drugs, so I think complementary therapies should be in some way accredited and in some way monitored so that it's at least safe for people.<sup>113</sup>

Again there is a certain *degree* of tolerance of lay practice within this last quote. While the majority of GPs perceive the potential risk of lay practice as a justification for unconventional therapies to be located *strictly within* the boundaries of general practice, this GP appears to acknowledge that lay therapy may constitute an acceptable and legitimate form of practice provided that certain cautionary measures

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<sup>109</sup> Dr 20.

<sup>110</sup> Dr 6.

<sup>111</sup> Dr 23.

<sup>112</sup> Dr 14.

are first put in to place. A few other GPs mirror this belief. Dr 21 explains how the lack of regulation and monitoring of the lay sector causes him concern when he comes to make referrals:

I wish there was some registration or some method by which I could, say they ask me and I would say I don't know if they're any good, you know, that they'll do anything dangerous to them whereas in the past it was a bit of a, you'd be worried sometimes the things that you heard getting done.<sup>114</sup>

Another GP expresses a similar concern with regard to lay therapy:

the thing is there aren't registers. I would always send someone to a registered osteopath but there aren't many other organisations that regulate the other therapies and until that is the case I probably wouldn't refer (patients) to other therapists.<sup>115</sup>

There has been much concern regarding the competence of lay therapists which has emanated from within the medical profession over recent years.<sup>116</sup> Prominent within this literature has been the second BMA report of 1993. In this report, the association aims to develop a positive model of good practice in complementary medicine, treating the provision of complementary treatments as a 'public health issue' and focusing upon safeguarding the patient from 'incompetent practitioners'.<sup>117</sup> The report, in line with some of the discursive constructions employed by the GPs here, gears itself towards the safety and protection of the consumer. These rhetorical constructions are illustrated in the following passage from the 1993 Report:

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<sup>113</sup> Dr 19.

<sup>114</sup> Dr 21.

<sup>115</sup> Dr 6.

<sup>116</sup> An example is Vickers, A. (1996). *Op. Cit. No. 4*. where he outlines adverse effects of complementary therapies as stemming from the non-registered practitioners in the lay sector. He states, 'most of the adverse side effects of complementary therapies found in the medical literature do not involve registered practitioners: this is one of the reasons why the use of such professionals is recommended'. p.265. For discussion of medically trained acupuncturists' concern about the safety of non-medically qualified therapists see Mann, F. (1973). *Acupuncture: Cure of Many Diseases*. London, Pan Books.

<sup>117</sup> BMA (1993). *Op. Cit. No. 4*. p.1.

doctors have a duty to the individual and to the community to safeguard the public health and, to this end, it is important that patients are protected against unskilled or unscrupulous practitioners of health care. It was therefore considered helpful for the BMA to consider, as a public health issue, the principles of good practice in non-conventional therapies which would safeguard the individual against possible harm to health and maximise the potential benefits of particular methods.<sup>118</sup>

Returning to the grass roots of general practice the following quote illustrates how one GP homeopath employs similar rhetoric in relation to his encouragement of patients to self-refer for complementary therapies outside of general practice<sup>119</sup> - though in this case the monitoring of other therapists' practices is seen as the responsibility of the GP him/herself. He states:

I'm quite open as long as I know what's going on, you know, if patients come to me and say look what do you think about me going to a chiropractor or an osteopath or somebody like that I'll say well let's look, if it's appropriate let's x-ray first, let's know exactly what's going on - then you can go off and do that if that's what you want to do but I think it's got to be carefully monitored. I'm probably quite careful with that, I think I'm quite careful who I refer to.<sup>120</sup>

#### 4.2.5.2 The Private Sector of Professional Self Interest

The private sector is condemned by most of the GPs as an environment that encourages the pursuit of 'self-interest' on the part of the practitioner. There is a suggestion by these GPs that lay therapists are influenced by financial considerations as a result of their need to survive in a competitive free market. Indeed, some social science commentators have drawn upon this issue as a possible 'contradiction' or 'tension' facing lay therapists in their attempts to justify an altruistic approach to practice.<sup>121</sup> However, some writers have proposed that privately financed therapy can

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<sup>118</sup> BMA (1993). *Ibid.* p.2.

<sup>119</sup> It must be noted that this GP highlights the therapies of osteopathy and chiropractic as referral therapies. This may be significant in terms of their status in the lay and medical worlds.

<sup>120</sup> Dr 20.

<sup>121</sup> Sharma, U. (1992). *Op. Cit.* No. 3. p.114.

often bring its own benefits for patients; it is argued that such payment may lead to practitioners being 'more sensitive to the lay evaluations of potential customers'.<sup>122</sup>

Most of the doctors interviewed in this study present a contrasting view. A GP explains his concern over payment: 'one's always cautious about private practice because, you know, especially when people are paying by the session...you wonder to what extent the financial angle influences therapy'.<sup>123</sup> This 'problem' of private practice is clearly contrasted to the motivation behind GPs' development of the therapies in the following quote from Dr 17.<sup>124</sup> He states:

I'm not saying they're not skilled, I think some of them are very skilled but they take longer than they should for financial considerations. I don't know about the ethics of what they're doing. I do know about my ethics and my colleagues' ethics in the field who are doing it. I mean, I'm not doing it for financial gain. I do treat other doctors' patients when they refer to me but I don't take money for it and I will say if you really want to make a donation choose a charity that you can donate to.<sup>125</sup>

Another GP makes similar claims with regard to the ethics of lay therapists and the motivations behind their practice:

I'm always aware that some of it might be money driven

Interviewer: What do you mean?

Well what do they, some thing behind, the motivation behind what they actually do. Is it purely because they want to do it? I mean, I certainly don't do my job because of the money that's for sure, but you know how much do they?<sup>126</sup>

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<sup>122</sup> Budd, S. and Sharma, U. (eds) (1994). *Op. Cit. No. 98*. pp.3-4.

<sup>123</sup> Dr 18.

<sup>124</sup> Effectively, general practice and the development of the therapies therein are seen as motivated by the patients needs not self interest. In this sense general practice is expressed in terms of a neutral or impartial approach to treatment and clinical decisions. This theme is further explored in chapter three of the analysis in relation to the GPs attempts to distance themselves and their practice from hospital medicine.

<sup>125</sup> Dr 17. This rhetorical construction is particularly interesting when considered alongside the issue of constraints of time upon integrative practice as examined in chapter two of the analysis.

<sup>126</sup> Dr 10.

The 'free service' of NHS general practice and the absence of financial considerations have been popular rhetorics employed by some sections of the medical profession to help highlight an altruistic ideal for practice. Research has suggested, for example, that those doctors 'who see a broad role for the general practitioner and tend to be innovative in their activities' place less emphasis upon financial incentives in their explanations and justifications of their work.<sup>127</sup> It would appear that this rhetoric is also prominent in the GPs' accounts examined here. One of the GPs explains how he sees a free service as an advantage to GP therapy. He suggests that the principle of providing treatment 'free at the point of service' makes clear to patients his dedication to the therapy. In addition, he implies that the trust and the credibility he enjoys as a GP serves to legitimate the medicine. This is illustrated in his suggestion that as a professional GP he 'wouldn't be wasting his time' on a therapy of no benefit. To quote him in full, he says:

I sometimes think that people when they pay for things have got greater expectations about their efficacy but I don't think that lasts, if it doesn't work it doesn't work. They pay for it and think I'm not sure about this then they won't pay twice. Here they're not paying at all and I don't, my wife tends to think it devalues what I do but I don't think so, I think it adds rather than devalues. I mean, I'd, I'm prepared to spend my time which is really valuable to me and my partners are prepared to let me take three and a half hours out of practice to do that then that is sending some sort of message to my patients and I do tell them that this is my time and that my partners have allowed me to pursue this interest and that I wouldn't be doing it unless I felt I was doing something useful, I wouldn't be wasting my time.<sup>128</sup>

In addition, Dr 10 suggests that getting complementary medicine for free on the NHS may be an advantage in general practice: 'on the whole the patients think [complementary medicine's] wonderful because they, also this idea being wonderful,

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<sup>127</sup> Calnan, M. (1988). 'Images of General Practice: The Perceptions of the Doctor'. *Social Science and Medicine* 27(6): 579-586. This article provides a description of general practice similar to that provided by the group of GPs studied in this thesis.

<sup>128</sup> Dr 17.

because they perceive them as a thing that you would usually have to pay for'.<sup>129</sup> This extract of talk suggests that general practice - as a service free at the point of treatment - is a beneficial environment for offering complementary therapies. This forms one particular linguistic strategy whereby these complementary therapies are appropriated to GPs' surgeries; a theme which will be explored in more detail in chapter five.

The need for lay therapists to attract patients and also retain their market share is seen by some GPs as leading to 'dependency' among patients. GP 14 below employs this discourse of 'dependency' with reference to non-medically trained hypnotherapists and their style of practice:

one thing that I'll say about lay therapists...traditional hypnotherapists don't teach patients self-hypnosis which sometimes makes them dependent and they need to go back for more sessions every time something's up with them, when in fact if you teach them self-hypnosis that can actually allow them to access all the stuff themselves.<sup>130</sup>

In contrast, many of the GPs construe their practice as facilitating self-help, empowering the patient to take a more active role in the consultation and in their health and well-being more generally.<sup>131</sup>

#### **4.2.6 Translation and Educators to the Public: Rhetorics of Faith, Trust and Accessibility**

The rhetoric of dependency when describing lay therapy also flows through the talk of most of the GPs in their explanations of another role and obligation regarding complementary medicine. They present themselves as the educators to the public; they

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<sup>129</sup> Dr 10.

<sup>130</sup> Dr 14.

<sup>131</sup> For example Dr 14 explains how patient participation and control is important to her idea of general practice. She says, 'that the patient has got control, that's important. I don't want control and I don't want them dependent on me because that's not appropriate and I don't think it allows people to heal properly'.



translate what are otherwise perceived as incomprehensible medical language and theories and make them digestible for patients. As illustrated earlier, some GPs argue that alternative therapy is couched in a medical language which is distanced and detached from mainstream culture (and therefore from the vast majority of patients), and thus occupies a marginal cultural position. Moreover, they claim that this alternative language is at best irrelevant and at worse a hindrance to good complementary practice. In this sense, some GPs project themselves as bringing the therapies to the people.<sup>132</sup>

Many of the doctors perceive their role in general practice (their continuity of care, personalised practice and their established location as part of the fabric of the local community) as aiding this *translation process*. GP 17 explains what he sees as the acceptability for the patients of practising the therapies himself rather than leaving them to some alternative therapist:

You'll get people saying, being taken aback that a GP's offering them this type of service but I've got faith in it and they trust me because I've been here twenty years they're willing to give it a go whereas they wouldn't really contemplate doing it by looking up the yellow pages.<sup>133</sup>

The terms faith and trust are commonly employed by the doctors to reflect what they see as the patients' perceptions of general practitioners. Dr 5 talks at length about what she sees as the trust patients have in their GPs, how this is absent in lay practice and how trust is central to good effective complementary therapy. She says:

the difference between GPs and lay therapists is that patients trust their GPs and they already should have built rapport with the patient, so the patients, it's the trust that's there and until you have trust you're unable to do anything with a patient. If you come to hypnosis the patient who does not trust the therapist will refuse to go into a trance and I've had patients who told me that they didn't trust a lay therapist and they were unable to get them into trance. They

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<sup>132</sup> As one GP put it, taking the therapy away from lay practitioners and locating them within general practice produced a sense of familiarity in that 'it's someone that you're dad sees'. Dr 24.

<sup>133</sup> Dr 17.

did not realise they were just, it was a protection mechanism, they had a feeling they didn't trust the person and the whole thing was totally unsuccessful. Patients have the idea that the doctor will make them better and if you have the continuation, the trust, the patients will accept the complementary therapies.<sup>134</sup>

Some GPs highlight this trust in terms of patients seeking advice and information from them about lay therapists and their medicines. Dr 3 says, 'they feel safer because they know that I know what's wrong with them. I mean, they will come in having seen a herbalist or a lay homeopath and say to me this medicine - is it all right?'.<sup>135</sup> Other GPs talk of the 'cultural tastes' of patients. These doctors claim that without the suggestion and approval of the GP many people 'might not be exposed to the therapies because of the views that they hold, they might just think no way would I go and see a hypnotist or N[euro] L[inguistic] P[rogramming] just in the scheme of things'.<sup>136</sup> Here the GPs clearly draw upon the discourse of access to justify their practice of a range of therapies. This interpretative repertoire is prominent in many of the accounts with GPs talking of their practice making complementary therapies 'accessible to patients',<sup>137</sup> and 'giving patients access to that range of medicines'.<sup>138</sup> As GP 12 puts it, 'one of the nice things if general practitioners do complementary medicine is that it's sort of much more *widespread*'.<sup>139</sup>

It is still the case that the vast majority of unconventional therapy provided in Britain is outside the NHS and practised by non-medically qualified therapists in the private sector,<sup>140</sup> and one rhetorical construction which links strongly within most accounts with this discourse of access relates to the cost of private lay practice and

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<sup>134</sup> Dr 5.

<sup>135</sup> Dr 3.

<sup>136</sup> Dr 17.

<sup>137</sup> Dr 25

<sup>138</sup> Dr 9.

<sup>139</sup> Dr 12.

equity of provision. As Dr 24 stresses, 'if it's given by your doctor then it's free...I'm always a bit concerned about the overall cost to the patient'.<sup>141</sup> This represents another rhetorical tool with which the GPs demarcate a boundary between lay practice and that of the general practitioner within the National Health Service, with many of the doctors suggesting that a main motivation for developing their practice of complementary therapies is the inability of many of their patients to afford private treatment. Dr 22 illustrates the use of this rhetorical device in her talk. She says:

I think that a reason I'm doing it is because that I feel a lot of my patients can't afford private acupuncture and they wouldn't get acupuncture any other way. If it's £30 for half an hour a lot of my patients are on income support and they just couldn't do it'.<sup>142</sup>

And elsewhere this same GP highlights both the issue of accessibility and also the possible exploitative nature of alternative therapy. Here she employs a particular anecdote regarding one of her patients who approached a lay homeopath for treatment for a sleeping problem to make her point:

I've had patients come and see me after they have seen some of these homeopaths. Now I don't want to run these people down, I really don't know that much about them, my main concern about them is the cost to the patient which, I mean just recently and this is quite spectacular I had a man come in and he was someone that I saw for an ongoing sleep problem over years and years and he has recently seen an homeopath. He was really stung for a great deal of money by remedies that are, you know the remedy we've no idea what they are and he charges him I think he said £30 a go and these remedies you can buy for a few pence over the counter.<sup>143</sup>

This quote contains a number of interesting features. First, the GP effectively distances the lay homeopath from what he presents as the core unit of the GP and patient. This is achieved through the use of the phrase 'we've no idea what they are'.

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<sup>140</sup> Sharma, U. (1992). *Op. Cit. No. 3*. p.93. Saks, M. (1994). 'Alternatives to Medicine'. In J. Gabe, D. Keheller and G. Williams (eds). *Challenging Medicine*. London, Routledge.

<sup>141</sup> Dr 24.

<sup>142</sup> Dr 22.

The doctor and patient are here rhetorically united in their questioning of the lay practitioner. Secondly, the GP also ridicules the competence and expertise of the homeopath. The £30 fee is presented as the charge for the remedy not as the fee for both remedy and the expert diagnosis and decision-making of the homeopath; this point is further developed when the GP equates the remedy offered with that which can be obtained directly 'over the counter'.

Dr 13 perceives cost to the patient as a major factor influencing the development of these therapies in general practice:

I think the big thing is that it's the balance between what we can afford to provide and how much do we encourage people to seek out these things for themselves because they can be quite pricey you know, and if, so if you're well off its not a problem but if you're not well off it is a problem.<sup>144</sup>

Research investigating the users of complementary therapies suggest that while patients appear to come from a wide range of backgrounds there is evidence that the majority in the UK are from social classes A and B rather than C, D and E.<sup>145</sup> Similarly, it has been suggested from poll data that people from lower classes are significantly less likely to be patients of unconventional medicines.<sup>146</sup> While acknowledging that in recent years a growing range of patients are seeking complementary treatment, social scientists have concluded from collating such secondary data that if people are inhibited from using complementary medicine it is, in part, due to their inability to afford such private treatment.<sup>147</sup> It would seem that these GPs developing complementary therapies within their surgery are keen to

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<sup>143</sup> Dr 22.

<sup>144</sup> Dr 13.

<sup>145</sup> Fulder, S. (1988). *The Handbook of Complementary Medicine*. Sevenoaks, Coronet Books.

<sup>146</sup> Research Surveys of Great Britain (1984). *Omnibus Survey on Alternative Medicine*. London, Swan House Special Events.

<sup>147</sup> Sharma, U. (1992). *Op. Cit. No. 3*. p.19. Huggon, T. and Trench, A. (1992). 'Brussels Post-1992: Protector or Prosecutor?'. In Saks, M. (ed.). *Op. Cit. No. 3*.

capitalise on such claims in their attempt to highlight the benefits of NHS GP therapy over that of private non-medically qualified therapists.

## **4.3 Summary and Discussion**

### **4.3.1 Demarcating Distance and Claiming a Role in Unconventional Practice**

As has been seen in this chapter the doctors interviewed for this study employ a number of discursive devices in their boundary demarcation between their own practice and that of lay therapists. Furthermore, processes of legitimacy and authenticity are pivotal to this boundary construction between themselves and lay therapists. Non-medically qualified therapists and their style of practice are presented by these GPs as illegitimate and non-authentic while, in contrast, a number of rhetorical constructions are employed to justify both general practice in broad terms and, more particularly, their own practice of complementary therapies.

The rhetorics of safety and risk are actively drawn upon in relation to this particular boundary-work and this rhetoric is useful for these doctors in their attempts to identify the general practitioner as vital to developing good complementary practice; the claim for a conventional base to unconventional therapy is made. This rhetorical claim is presented in two distinct yet related ways. First, the majority of the GPs construct all lay practice (under any circumstances) as potentially harmful and detrimental to the patient. In this case, the GPs' talk implies a direct and central role for the GP in complementary practice. Basically, unconventional therapy should be practised exclusively by the medically trained.<sup>148</sup> This approach is further illustrated by the refusal of the majority of the GPs in the study to refer patients to the non-medically qualified. A second position identified in these accounts, which is presented by the minority of doctors, indicates that lay therapy is not necessarily irrelevant to patient care and that, under certain conditions, referrals to lay therapists are



acceptable. However, these GPs do stress a governing condition in relation to this scenario which still renders the GP vital to unconventional treatment. Effectively, these GPs construct themselves as essential gatekeepers to private lay practice. There have been similar claims made by medical writers. Jonas proposes a need for a 'generalist gatekeeper' who can co-ordinate integrative treatment and be principally responsible for the overall welfare of the patient. He writes:

as the number, type and background of complementary practitioners increases and as the identification of more and more effective and ineffective complementary therapies occurs, a generalist gatekeeper and medical co-ordinator with knowledge of complementary and conventional medicine will be needed to prevent misapplication.<sup>149</sup>

Further support for this stance can be identified both from the BMA<sup>150</sup> and in the GMC ruling in the mid-1970s which formally acknowledged the GP's right to refer to alternative therapists as long as the GP retains overall responsibility for the patient.<sup>151</sup>

#### 4.3.2 Specialism or Generalism?

One theme which can be identified within the GPs' accounts is how the majority of the doctors construct legitimate 'complementary' therapy as specialism (and incidentally lay therapists as specialists who inappropriately perceive themselves as generalists). Indeed, some of the GPs' perceptions of lay therapists as over-adventurous, and the stress they place upon misappropriation of the therapies by these lay practitioners, would seem to clearly illustrate this specialist construction. In presenting the opposing styles of complementary and alternative practice - more

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<sup>148</sup> This argument has also been forwarded by some elite bodies representing GPs practising unconventional therapies (e.g. the British Medical Acupuncture Society). See Saks, M. (1992). *Op. Cit.* No. 4. p.189.

<sup>149</sup> Jonas, W. (1996). *Op. Cit.* No. 26. p.134.

<sup>150</sup> BMA (1988). *Philosophy and Practice of Medical Ethics*. London, BMA.

<sup>151</sup> Budd, S. and Sharma, U. (eds) (1994). *Op. Cit.* No. 98.

particularly, in their demarcation between these styles which centres upon the suitable time and place for unconventional treatment - the GPs propose a specialist role for the therapies. They are to be seen, so their accounts suggest, as *techniques* to be administered only after a conventional diagnosis has been undertaken and the opportunity for conventional treatment has been considered by a medically qualified doctor.

While some social scientists suggest that GPs more generally tend to regard unconventional therapists as providing specialist health care services,<sup>152</sup> many alternative therapists would appear to perceive their medicines and themselves as healers occupying a generalist role.<sup>153</sup> Indeed, Peters (himself a GP) has cautioned against the interpretation of complementary therapies as specialisms and lay therapists as specialists. Writing specifically about his experiences in helping establish interprofessional collaboration between GPs and complementary therapists, he argues that complementary practitioners may be more appropriately understood as generalists 'who share many of the primary care team's attitude to health care'.<sup>154</sup> Moreover, as Peters himself points out, 'the image of the [complementary practitioner] as specialist is an obstacle to co-operation, especially if, as Balint suggests, GPs infantilize themselves by their fantasies of specialists' power to cure'.<sup>155</sup>

As will be seen in chapter five talk of specialist medicine is used by the GPs in their descriptions of hospital doctors and hospital medicine.<sup>156</sup> These common discursive constructions help the GPs in their attempt to claim a unique medical

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<sup>152</sup> Busby, H., Williams, G. and Rogers, A. (1997). 'Bodies of Knowledge: Lay and Biomedical Understandings of Musculoskeletal Disorders'. In M. A. Elston (ed.). *The Sociology of Medical Science and Technology*. Oxford, Blackwell.

<sup>153</sup> See Cant, S. and Calnan, M. (1991). *op. cit.* no. 82.

<sup>154</sup> Davis, P. (1994). 'Sharing Responsibility for Patient Care'. In S. Budd and U. Sharma (eds). *Op. Cit. No. 98*. p.177.

<sup>155</sup> Davis, P. (1994). *Ibid.* p.176.

function as distinct from both their hospital counterparts and non-medically qualified therapists.

#### 4.3.3 Protecting Medical Dominance and Status

As outlined earlier in this thesis, Saks has highlighted how the incorporation of complementary therapies by the medical profession in recent years can be seen as a response to the threat posed by alternative therapists to the profession's dominance and status.<sup>157</sup> While this study has focused upon the specific professional group of general practitioners using complementary therapies as opposed to the medical profession as a whole, the GPs' accounts do provide further evidence of such professional self-interest. They illustrate how the talk of grass-roots doctors presents unconventional therapies as in need of *medicalization* and how the integration of these therapies into general practice is accompanied by attempts to distance from and problematise the practice of non-medically qualified therapists. Also in line with Saks's argument, the GPs' talk illustrates a perception of a limited or restricted complementary role for the therapies; treating them as specialisms which require the context of a conventional medical base. As reflected in earlier work such rhetorical constructions have often been central to the medical profession's maintenance of dominance over other groups in the medical arena such as nurses and physiotherapists.<sup>158</sup>

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<sup>156</sup> This is a theme more fully explored in chapter seven and the concluding chapter.

<sup>157</sup> Saks, M. (1992). *Op. Cit. No. 3*.

<sup>158</sup> Larkin, G. (1983). *Occupational Monopoly and Modern Medicine*. London, Tavistock. Wardwell, W. (1962). 'Limited, Marginal and Quasi Practitioners'. In H. Freeman (ed.). *Handbook of Medical Sociology*. Englewood Cliffs, N. J., Prentice Hall. and as Abbott claims, 'the diagnostic classification system makes some problems residual ones, placing groups that specialize in them at a disadvantage in competition with the incumbents', Abbott, A. (1988). *The System of Professions*. Chicago, Chicago University Press. p.136.

However, there is arguably another intertwined process present in the GPs' talk outlined so far. Distancing is part of the appropriation process whereby this group of GPs practising complementary therapies attempt to reconcile tensions in their practice. These GPs also need to justify to others in general practice and the medical profession more generally that their practice of these therapies is worthwhile and authentic. In this sense, much of the rhetoric analysed in this chapter can be seen as an attempt to not only distance themselves from lay practice but to claim unconventional therapies as a legitimate component within the remit of general practice. For example the claim that the public need protection from lay therapists which is provided by GPs help these doctors justify their involvement in unconventional treatments. The next chapter draws out this appropriation process further through a more focused examination of the GPs' constructions of the clinical realities of integrative practice. It is to this particular theme, and to other issues relating more directly to the particular setting of general practice and the perceptions of fellow colleagues therein, that the thesis now turns.

## **Chapter Five**

### **Appropriation, Authentication and Constraints: A Focus Upon the Construction of Clinical Reality of Integrative Practice**

## 5.1 Introduction

It's a major problem when you're competing, speaking to your colleagues because what they throw at you. The tablets you're giving there's nothing there, you know it's rubbish, it's all placebo, bin it!

Interviewer: And your reaction to those claims?

I mean well it's just if it works it works. It's probably my approach now and probably was then as well...*It's cheap, it's side-effects free*, if it works let's give it.<sup>1</sup>

[Acupuncture] is attractive because if you're careful with it it's completely non-toxic and completely free of side-effects, very cheap and it offers a prospect of maybe longer term care or palliation of symptoms that western medicine can't provide. It is very attractive.<sup>2</sup>

In this chapter I would like to momentarily redirect attention away from the analysis of boundary-construction within the GPs' accounts, to examine issues which relate more directly to the appropriation and authentication of unconventional therapies into the particular setting of general practice.<sup>3</sup> Alongside these two issues this chapter also examines a number of constraints which the GPs describe in relation to their attempts to integrate unconventional therapies into their practice regimes. While a number of distinct constraints are reported (e.g. restrictions imposed by practice colleagues and the circumstances of remuneration and organisational structure) these all link, in one way or another, to notions of time, time management and efficiency in general practice. Indeed, the issue of time constraint in relation to integrative practice dominates much talk within all the GPs' accounts and it is to this

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<sup>1</sup> Dr 20.

<sup>2</sup> Dr 19.

<sup>3</sup> It must be noted however that while appropriation and authentication processes are distinct from boundary-construction and can be analytically explored in isolation, they are not divorced from issues of demarcation. To legitimise a certain role and identity for complementary medicine within general practice also means making judgements of 'value' and 'worth'. In this sense, the rhetorical claims and devices surrounding appropriation not only help carve out legitimate therapeutic practice but also, in turn, help represent alternative possibilities and formulations as less or inauthentic.



issue and the wider context of time and efficiency within general practice that the chapter now turns attention.

## 5.2. Time as Constraint

### 5.2.1 The Increasing Concern with Time and Efficiency in General Practice

Despite the GP's personal experience of space and time as external and objective, there are grounds for examining them as social constructions...the spatial and temporal features of GPs' perceptions of their work [are] themselves integrally bound up with the social organisation and activities of that work.<sup>4</sup>

[T]he pace of life in general practice is dictated by yourself. As soon as I've said that it's a lie - it's dictated by these thousands of patients sitting in the waiting room all with an appointment and you know you only have to nip to the loo and that's your day, you're out!<sup>5</sup>

Before examining the talk of time and efficiency by these GPs in relation to their practice of complementary therapies it is first necessary to briefly chart the increasing concern with these two issues within general practice more widely.

Since the first half of the twentieth century general practice has experienced a particular historical development of surgery location and organisation. In more recent years there has been a near universal shift away from the domestic setting and single-handed practice to either health centres or group surgery premises.<sup>6</sup> These developments have helped foster concern with the spatial and temporal aspects of general practice. Group settings have encouraged appointment systems,<sup>7</sup> heightened demarcation of room space and its allocation for activities such as diagnosis, consultation, arrival and waiting to see the doctor. In addition, the move from a 'cottage-industry' setting, where GPs practised single-handedly from their own homes, to the purpose-built practice often housing a number of partners and other

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<sup>4</sup> Armstrong, D. (1988). 'Space and Time in British General Practice'. In M. Lock, & D. R. Gordon (eds). *Biomedicine Examined*. London, Kluwer Academic. p.207.

<sup>5</sup> Dr 10.

<sup>6</sup> See Armstrong, D. (1988). *Ibid.* p.208. Harding, G. and Taylor, K. (1995). 'General Practitioners and Community Pharmacists: Interprofessional Relations in Health Centres'. In K. Soothill, L. Mackay and C. Webb (eds). *Interprofessional Relations in Health Care*. London, Edward Arnold.

<sup>7</sup> A good example of the development of appointment systems is seen in the two studies of general practice by Cartwright. See Cartwright, A. (1967). *Patients and Their Doctors*. London, Routledge and Kegan Paul. Cartwright, A. & Anderson, R. (1981). *General Practice Revisited*. London, Tavistock.

associated personnel, has been accompanied by a demarcation of 'time at work' from 'time off work'. This means that whereas the single-handed GP would, theoretically at least, provide medical assistance and advice twenty four hours a day, the modern GP located in a group practice has periods of time which are 'cut off' from medical duties and responsibilities.<sup>8</sup> These features have exacerbated the concern with 'time as pressure' and 'time as constraint' in the working life of the general practitioner.<sup>9</sup>

### 5.2.2 Time and Complementary Practice

I think the one thing that's against [integration] is the lack of time and I think it says something that there are so many GPs involved in complementary therapies because it's actually very difficult to find the time.<sup>10</sup>

I had a lady in with chronic back pain. I've still got this back pain doctor! I said I'm sorry you're going to have it for, I really don't have any magic treatments to give you know, erm, but I gave her some rhus tox because she was very very stiff in a morning and as I gave it to her I thought, I was aware I was only going on one feature here, the stiffness and the pain and you know through the consultation other things came out and she would be one that would be quite nice to sit down and say can I ask you a few more questions but I knew I was doing the surgery and the antenatal clinic and everything else.<sup>11</sup>

Think of all the alternative therapies. How many of them take two minutes? How many of them do they walk in and get handed something or just looked at and disappear out the door? The only place is in the ordinary doctors' surgeries but for the most part all these alternative therapies involve time with people. That's what I feel all along that's important about all these alternative therapies and why they work is that people are given time so if we could all afford to give an hour to our patients all over the place then you know then probably they wouldn't come back but nobody has got the courage to say I'll see three patients this morning thank you.<sup>12</sup>

I think there's probably a bit more, hopefully a lot more patient contact, you know its not just get the diagnosis and get them out, its a bit more time but it is time consuming.<sup>13</sup>

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<sup>8</sup> For discussion of this point with reference to the urban/rural GP divide see, Horobin, G. & McIntosh, J. (1983). 'Time, Risk and Routine in General Practice'. *The Sociology of Health and Illness* 5(3): 312-331.

<sup>9</sup> Calnan, M. & Butler, J. R. (1988). 'The Economy of Time in General Practice: An Assessment of the Influence of List Size'. *Social Science and Medicine* 26(4): 435-441.

<sup>10</sup> Dr 23.

<sup>11</sup> Dr 7.

<sup>12</sup> Dr 16.

<sup>13</sup> Dr 20.

A major theme of both interest and concern among sociologists and other commentators has been the type of complementary medical practice encouraged and promoted within the setting of the National Health Service.<sup>14</sup> A central component of such debate has been the issue of time.

Some writers have contrasted what they see as the different time constraints facing non-medically qualified practitioners in the private sector on the one hand, and those members of the medical profession developing complementary services within the setting of the National Health Service on the other.<sup>15</sup> Similar distinctions have also been made by lay practitioners in their attempts to defend their practice from medical interest.<sup>16</sup> Furthermore, it has been suggested that patients - in line with their growing disillusionment with the dehumanising aspects of modern medicine - have opted for unconventional treatment partly through the attraction of long consultation times.<sup>17</sup> Certainly, research does suggest that the average consultation with a lay therapist is longer than that with a GP.<sup>18</sup>

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<sup>14</sup> For example see Featherstone, C. and Forsyth, L. (1997). *Medical Marriage*. Forres, Scotland, Findhorn Press.

<sup>15</sup> Sharma, U. (1994). 'The Equation of Responsibility: Complementary Practitioners and Their Patients'. In S. Budd & U. Sharma (eds). *The Healing Bond: The Practitioner-Patient Relationship and Therapeutic Responsibility*. London, Routledge. Taylor, R. C. (1984). 'Alternative Medicine and the Medical Encounter in Britain and the United States'. In J. W. Salmon (ed.). *Alternative Medicines: Popular and Policy Perspectives*. London, Tavistock.

<sup>16</sup> Cant, S. & Calnan, M. (1991). 'On the Margins of the Medical Marketplace? An Exploratory Study of Alternative Practitioners' Perceptions'. *Sociology of Health and Illness* 13(1): 39-57.

<sup>17</sup> For discussion of this disillusionment see Trevelyn, J. (1995). 'The New Fringe?'. *Nursing Times* 91(11): 26-28. BMA (1986). *Alternative Therapy: Report of the Board of Science and Education*. London, BMA. Regarding the longer consultations of complementary treatments and how these attract patients see Taylor, R. C. (1984). *Op. Cit. No. 15*. Saks, M. (1994). 'The Alternatives to Medicine'. In J. Gabe, D. Keheller & G. Williams (eds). *Challenging Medicine*. London, Routledge. Douglas, M. (1994). 'The Construction of the Physician: A Cultural Approach to Medical Fashions'. In S. Budd & U. Sharma (eds). *Op. Cit. No. 15*. Linked to these interpretations have obviously been a number of other factors which writers suggest attract patients to alternative practitioners. For example, for a discussion of research into patient satisfaction generally and the bedside manner of conventional and complementary therapists in particular, see Ernst, E. & Resch, K. I. (1997). 'Do Complementary Practitioners Have a Better Bedside Manner than Physicians?'. *Journal of the Royal Society of Medicine* 90: 188-190.

<sup>18</sup> See Davies, P. (1984). *Report on Trends in Complementary Medicine*. London, Institute for Complementary Medicine. Fulder, S. & Munro, R. (1981). *The Status of Complementary Medicine in the UK*. London, Threshold Foundation. Anderson, E. & Anderson, P. (1987). 'General Practitioners

Previous research has shown how time is a dominant theme in general practitioners' talk about their work and how GPs employ notions of time as a constraint or pressure when explaining specific areas of their practice.<sup>19</sup> Given the emphasis different commentators and medical groups have placed upon encouraging time to practise different therapies it is not surprising to find nearly all the GPs in the present study presenting time as a restriction to their development of complementary medicines.

Dr 23 echoes a view presented by many of the GPs in the study when he explains how his complementary therapy (acupuncture) is time consuming:

sometimes you sit in a consultation and you say well I could give this patient an anti-inflammatory painkiller or I could get them to come back and see me and it's easier to give them a tablet because you give them a prescription OK they might come back in a month for another prescription but with acupuncture you're going to have to give them at least three double appointments, which is six appointments over a period of three or four weeks which is time consuming.<sup>20</sup>

This doctor draws a direct contrast between his practice of acupuncture and more traditional drug-based treatments by highlighting the extra time involved in providing his complementary therapy. This contrasting imagery is common across many of the accounts. Thus Dr 3 outlines the environment of general practice and the range of tasks therein as creating a particular dilemma with regard to his practice of homeopathy and hypnotherapy:

If I have a surgery that takes me three hours to do and then I've got four house calls and then another surgery in the afternoon and paper work and reports and

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and Alternative Medicine'. *Journal of the Royal College of General Practitioners* 37: 52-55. Sharma, U. (1992). *Complementary Medicine Today: Practitioners and Patients*. London, Routledge. p.41. Higgins claims that a similar phenomena may be at work with private orthodox practice too, see Higgins, J. (1988). *The Business of Medicine*. London, Macmillan.

<sup>19</sup> For example Horobin and McIntosh outline how some GPs in their sample from North East Scotland suggest that time constrains their practice of preventive medicine. Horobin, G. and McIntosh, J. (1983). *Op. Cit.* No.8. p.317.

<sup>20</sup> Dr 23.

writing letters and forty or fifty prescriptions to sign that's a full day. I don't want to take an hour out of that to see one patient. Well if you're doing homeopathy properly and you're taking a proper history it'll take you an hour. You may find the answer in that but it takes an hour when you're seeing nobody else and the hypnosis is the same. I mean your first interview will be an hour and you may have half hourly interviews maybe for three or four occasions before you stop which is a lot of time to invest in one patient.<sup>21</sup>

In this quote we can detect a popular rhetorical tool used by a number of the GPs in their portrayal of time constraints. It is noticeable that this GP portrays the dilemma of integration in terms of a responsibility to the wider practice population. There is a suggestion here that other patients will possibly be denied the time they require. There would seem to be an implication that the GP has to achieve a tricky balancing act: on the one hand, she has to remain aware that complementary therapies such as homeopathy 'may find the answer' to the problems of particular patients; on the other hand, she remains sensitive to the hazards of investing a lot of time in one patient.<sup>22</sup>

Other doctors also talk of the tension between the time involvement with complementary therapy and the requirement that they treat a certain number of patients. For example Dr 16 explains how practising hypnotherapy in normal surgery time is difficult for her to achieve. She says:

you'd have at the end of the day twenty people sitting in the waiting room and you've just seen one and the queue would be horrendous there's always a pressure on you, you're very aware of the time constraints.<sup>23</sup>

Dr 12 also talks of time as a problem of integrative practice when he says:

The problem is, I mean I could use them an awful lot more but the thing, we're just totally time restricted you know we can't get enough consultations for allopathic medicine, it's very hard to add in homeopathic and acupuncture and

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<sup>21</sup> Dr 3.

<sup>22</sup> This presentation falls in line with some writing on general practice. Gordon for example has stressed the significance within general practice of the tensions between 'patient priorities' and 'practice priorities'. See Gordon, P. (1995). 'Core Values'. *Health Service Journal*. 105(5452): 24-25.

<sup>23</sup> Dr 16.

our consultation rate already in the practice is quite high so it's very difficult to get the doctor time to do that.<sup>24</sup>

And on a similar note Dr 10 explains:

I certainly wouldn't book someone in for hypnosis or for acupuncture in the middle of an ordinary surgery because too often you can have a situation where you can, you can have this at any time when you're consulting but you have this situation not anticipated where a person wants to talk about something or unload something and that is definitely much more common when you're doing something which is either hands-on like acupuncture or hypnosis which they will perceive as being special and so they are more likely to have something they want to talk about but also you're more involved in explanation of the process itself in a way that you're not in other situations.<sup>25</sup>

Here the GP portrays complementary consultations as leading to longer involvement with the patient creating problems in the surgery timetable. Furthermore, this presentation also suggests that the patients themselves often contribute to the problem of extended consultations due to their heightened expectations. This style of explanation places the burden of longer consultations and time inefficiency upon patients as well as doctors and thereby can help reflect criticism that these GPs are simply exploiting longer consultations to see fewer patients.<sup>26</sup>

Some GPs attempt to contextualise the difficulties associated with long complementary medical consultations in terms of their consultation speed more generally. An extract from the talk of Dr 10 about her integrative practice helps illustrate this point:

I involve the patient and this can be quite new and bizarre to patients when I'll say and what do you think about that and why don't we do this and I'll say and I'll tell them back what I think they've said to me and it's a bit more time consuming and I'll know that, I am slow in general practice. I'm not, I mean I don't have this map of ten minute appointments. I always run late, but they know I'm on because the waiting room's full so it's not just I'm late it's cause they want to come.<sup>27</sup>

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<sup>24</sup> Dr 12.

<sup>25</sup> Dr 10.



This GP suggests that she is slower than others working in general practice. She portrays running late and taking more time with the patient as a normal feature of her general practice. This helps defend the GP from criticism that her complementary therapy consultation is significantly divorced from more traditional consultations and thereby unsuitable for the GP's surgery. Dr 15 expands a similar theme in his talk about the varying speeds of different practitioners more generally:

I think some general practitioners it's very clear that they can process people in ten minutes and feel OK about it as long as the surgery is on time. I suspect that those of us who can't are offering something else even if that is just an inefficiency or if it's chatting, there's creativity in chatting with people it makes them feel valued and all sorts of things.<sup>28</sup>

And this same doctor augments this claim a little later when he states of his complementary practice:

I always start on time and I would obviously never finish on time, surgeries would always be half an hour to an hour over...that's every consultation with every patient, I what feels right within me that if something comes up it has to be dealt with so if somebody starts to cry I within myself cannot say cannot feel it right to stop them crying, you know just stop them and get them out the door and say now you make an appointment and see me, it feels to me that what comes up in the consultation is the business of that consultation and I go on the premise that I hope that other people sitting waiting remember the day that it happened to them.<sup>29</sup>

Here the GP attempts to justify and authenticate the extra time taken to practise complementary medicine by suggesting this approach often facilitates helpful doctoring. The doctor draws upon images of empathy with the patient and patients' feelings as authentic features of legitimate consultations - again this bridges any distance which critics may claim lies between complementary and more conventional consultations. As will be seen in chapter six this feature of 'appropriate doctoring' is

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<sup>26</sup> This is a theme which links with the rhetoric of dependency discussed later in this chapter.

<sup>27</sup> Dr 10.

<sup>28</sup> Dr 9.

<sup>29</sup> Dr 15.

also central to many of the GPs' presentations of the 'valued' role of complementary therapies in their wider practice.

Dr 17 also talks of the speed of consulting as a means of explaining hypnotherapy. Here he is talking about a partner in his practice:

Dr [X] went on a hypnotherapy course but he doesn't practise it because it doesn't suit his consulting style

Interviewer: can you explain that then?

Because he works fast, you know bum doesn't hit the seat before you're out the door again right so. I mean patients say to me about him and he knows that himself so I'm not talking behind his back but I think it's too slow for him. Now I'm not saying I'm not a fast worker I can work as fast as I need to work. You get some doctors who are very slow, I'm by no means the slowest doctor in this practice.<sup>30</sup>

Like the other GPs quoted above this doctor associates the practice of complementary therapy (in this case hypnotherapy) with GPs who have a relatively slow consulting style. What is interesting in this quote is the way the GP is keen to clarify that he isn't too slow; this alerts us to the GP's concern with time management and efficiency.

Another way in which this talk may help domesticate complementary therapies within the setting of general practice is that it justifies only piecemeal integration; not all GPs are suited to complementary practice and therefore not all GP surgeries are appropriate environments for integration. In effect the above GP implicitly acknowledges more than one acceptable approach to or style of general practice and this helps justify the appropriation of complementary therapies within his surgery while still accommodating those GPs who do not take an interest in or develop practice skills in other medicines. This may be an important style of argument in encouraging other less interested GPs to allow complementary therapy enthusiasts in

their ranks to establish integrative practice; viewing general practice as idiosyncratic and as housing a spectrum of legitimate practice styles helps to diffuse antagonistic relations and confrontations between GPs personally involved with complementary medicines and those GPs critical of such involvement.

Dr 15 explains what he sees as the barrier of time restricting his practice of complementary therapies:

one of the problems in practice is that, the time commitment to engage in any of these therapies

Interviewer: Can you explain this for me?

Well the system doesn't encourage it. You're not, that we are not in any way paid for the time we give, so if I give somebody an hour's counselling time basically it's because I want to do it and spend my time that way rather than seeing six patients and giving them ten minutes consultations and treating them that way and you know that hour would enable me to look after another I don't know a number of patients and it's the number of patients coming in that gives you the money not the quality of stuff you do.<sup>31</sup>

This GP presents the constraint of time in terms of the remuneration and organisation of general practice more generally. This style of argument fits comfortably alongside that talk identified earlier in this chapter which signals a tension between patient and practice priorities; the talk of this particular GP suggests that the current organisation of general practice (whether intentional or not) favours practice priorities over those of individual patients. However, as the next section illustrates, many other GPs are keen to associate the issue of time management and constraint with the attitude and stance of fellow practice partners.

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<sup>30</sup> Dr 17.

### 5.2.3 Colleague Constraints

When talking about time constraint in relation to their complementary therapies many GPs frame this limitation in terms of the expectations and reactions of practice partners. For example Dr 23 says:

In general practice I'm very limited by the amount of appointments I've got and I'm very conscious of the fact that the most I can give somebody is usually 15 minutes, which ideally is not really long enough and because of that I select the cases I do and I have to limit the numbers I do otherwise my partners would start complaining saying my appointments were getting booked up so I very much limit myself.<sup>32</sup>

Another GP practising homeopathy and hypnotherapy explains:

I used to block off appointments to do it I used to take off a Tuesday afternoon and my partners were really you know unpleasant about it. My current partners are fine but in those days I had different partners and it was kind of considered it was my baby and if there was work that came in for the practice on a Tuesday afternoon they wouldn't pick it up it was kind of left for me, there was a lot of behind the scenes, this was annoying.<sup>33</sup>

This GP presents partners at a previous practice as attempting to constrain his practice of homeopathy by strategically supplementing his workload and thereby imposing even tighter time constrictions on his integrative practice. The GP highlights this hostile environment as a constraint upon his attempt to organise complementary medical consultations outside normal surgery. Another doctor talks of her practice partners in a similar manner:

they just didn't want to know about the therapies. None of them would ever come and say, any discussion about erm, how they were used. They were totally disinterested

Interview: And would they ever say anything about them?

Oh the argument would be at a practice meeting that I would have to erm, get my consulting rates sorted out and keep to time.<sup>34</sup>

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<sup>31</sup> Dr 15.

<sup>32</sup> Dr 23.

<sup>33</sup> Dr 3.

<sup>34</sup> Dr 5.

This quote illustrates quite clearly how the GPs' accounts present issues of time as central to attacks from other partners opposed to the integration of complementary therapies.<sup>35</sup> Dr 11 also talks about the restrictions of group practice. She explains in the following way:

My last practice was very holistic and you know we all had something that we contributed outwith conventional medicine so that wasn't really an issue other than when you know the inevitable times when people are away on holiday somebody else is off sick the girls are screaming at you that there aren't enough appointments and suddenly it's obvious that you're seeing Mrs Bloggs for the eighth week in a row you know for her smoking and you know, are you winning and you know within yourself without any of those saying that uhm, this is something that probably I should be dropping at the moment. It's never got to blows type of situation but you know yourself you think well I don't know there's somebody out there with a pneumonia needs an appointment to come in for an antibiotic and I'm seeing Mrs Bloggs.<sup>36</sup>

Here the doctor explains that her practice partners are supportive of her integrative practice but that in certain circumstances practice demands just become too great and the longer complex cases of acupuncture treatment spanning a number of weekly sessions 'should be dropped'. Once again, the talk conjures up a powerful image of 'others' in the practice heavily influencing choices as to when complementary therapies can appropriately be practised. However the GP claims such influence doesn't even have to be confrontational; simply through her own sense of responsibility the doctor limits her practice to fit with the expectations and perceptions of partners and other practice staff.

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<sup>35</sup> This same GP outlines this same theme elsewhere in her account. She says of her practice partners: 'they weren't even willing to read about it, to discuss it and one trainee said they used to make jokes about it. I wasn't in the Thursday morning and they sorted out normally on the Thursday morning gathered together and...they made jokes about me and my homeopathic tablets'. This same GP also highlights a similar point about time and partners' attitudes with regard to in-practice referrals: 'Well partners will refer people to you for treatment and then say this isn't good enough your surgeries are running late'.

<sup>36</sup> Dr 11.

Dr 13, practising homeopathy and hypnotherapy, also portrays the attitudes of practice partners as an important factor in organising time to integrate additional complementary therapies into the GP's surgery. She says:

we're particularly fortunate in our practice, maybe we're careful in selecting partners I don't know but certainly in our practice all the practitioners do have quite a holistic view of healing and enabling and so if I was in a different practice and I wanted to do some counselling or I wanted to do some hypnosis then I might not have the freedom to do that in a different practice if the other partners didn't have the same opinion about it if they thought you were just kidding yourself and having a nice relaxing time doing it so because we, well we do follow these other approaches and we encourage each other to try and find a wee bit of time to develop and I think it's a lot easier in our practice because of that.<sup>37</sup>

This doctor emphasises not only the potential constraints of group practice but also how the collaboration and positive attitudes of colleagues can create greater opportunities for complementary medical practice. The talk also incorporates reference to the speed and length of complementary treatments as perceived by others in the profession. The doctor portrays some other GPs as identifying the practice of complementary therapies within general practice as an excuse to have 'a nice relaxing time doing it' - again, this talk accentuates the effective use of time as a central issue with regard to the everyday organisation of group practice.

As can be seen from the passages of talk in this section the notion of group practice is drawn upon by the GPs in two ways. First, and most commonly, some GPs link group practice to the constraints upon their development of complementary practice - partners have the ability through their own allocation of practice time and organisation to influence the amount of complementary treatment integrated by others. On the other hand, group practice can also be presented as positive to integration with some GPs stressing the collaborative efforts of partners and how their 'similar

outlook' to practice eases the problems of time management associated with developing complementary medicines in general practice.

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<sup>37</sup> Dr 13.



### 5.3 Combating the Problem of Time: Restricting the Scope of Therapy

It's not the most important part of my general practice. I mean it's very limited so because of that I feel it has a role to play but it's not the most important thing that I do in general practice but it's an extra thing that I do where I see there's a great need for it and where I think I can help, so I mean *cases are selected quite carefully*.<sup>38</sup>

I do tend to choose my acupuncture patients because of the logistics of time.<sup>39</sup>

I'm probably quite selective in who I treat in a funny sort of way, in that patients come in you think yes I think that would do well with such and such a remedy, you know, the bell rings and you think right that would do and you would offer them homeopathy whereas the person who you're not sure what to use, say in homeopathic terms, you think phew this is going to be time consuming, I'll need to take a full history and therefore you would opt out probably.<sup>40</sup>

Closely bound up with the GPs' talk of time constraints and efficiency is the issue of when to incorporate complementary therapies into the GPs' schedule. Across the accounts we can identify two general models of direct integration.<sup>41</sup>

First, there is talk of allocating time separate from routine surgery hours purely to the practice of complementary therapies. GPs suggest this can be accomplished either through scheduling appropriate patients to return at the end of normal surgery (i.e. in spare time in the evenings) or through establishing a portion of time during the day to undertake complementary treatments (e.g. in a complementary medicine clinic). For example Dr 10 says:

quite often with acupuncture I'll say what we'll do is we're going to try some acupuncture now and I'll not do it there and then not unless I'm only going to put in you know six needles for five minutes. But in acupuncture there's the plain matter of fact that those needles need to stay in there and they need to be twiddled with and there's the actual time, that takes a certain amount of time so what I'll do is bring them back at the end of the surgery but it's worth it, it's

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<sup>38</sup> Dr 23.

<sup>39</sup> Dr 11.

<sup>40</sup> Dr 20.

<sup>41</sup> These models as identified from the GPs' accounts augment the presentations of similar doctors questioned in earlier studies. For an example of one such earlier study see Dale, A. (1996). 'Practising Acupuncture Today: A Postal Questionnaire of Medical Practitioners'. *Acupuncture in Medicine* 14(2): 104-108.

worth it because it works for the patient, even if it took an hour and half if it works for the patient it's worth it.<sup>42</sup>

Secondly, it is also suggested by some GPs that complementary therapies can be, and should be, practised within the normal surgery rather than establishing extra time elsewhere:

It's really from the point of view of flexibility for the patients. I mean a lot of them are working and I feel that if they have more choice of appointments then it's more suitable for them. I find the problem with anything whether it be acupuncture or anything else if you have one set clinic it limits the patients very much to a particular time and that doesn't suit everybody so I've consciously done it within the normal surgery.<sup>43</sup>

As seen in the last section some GPs claim that practice partners attempt to restrict integrative practice through discouraging the use of unconventional treatments in normal surgery time. As a result some GPs are forced to choose between either treating patients with complementary therapies in their spare time or not at all - circumstances which quite clearly make substantial or extensive integration difficult and problematic. The quote from Dr 23 above provides one example of how some doctors who argue in favour of integrative practice in their surgeries may attempt to justify making unconventional medical consultations an authentic component of practice within normal surgery hours.

As shown above, some GPs suggest complementary therapies can be practised within normal surgery time. Given the frequent presentation within the accounts of the time difficulties facing integration this presentation alerts us to an important question: how do the GPs suggest the constraints of time can be overcome? In response, we can identify a number of rhetorical devices by which these GPs present complementary

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<sup>42</sup> Dr 10.

<sup>43</sup> Dr 23.

therapies as adaptable and therefore suitable to the restrictions of normal surgery times within the NHS.

This section outlines three broad and deeply integrated rhetorical themes identifiable in the GPs' accounts. First, the GPs characterise styles of treatment in terms of the consultation time involved; they suggest that, by one means or another, non-conventional consultations (which lay practitioners would normally expect to take longer than an ordinary GP consultation) can be quickened and in this sense made more convenient for the 'busy' GP pressured by time. Second, and often closely linked to this talk of 'styles', is a claim that more efficient use of unconventional therapies can be achieved by limiting them to a certain restricted range of medical conditions. Finally, the section highlights how talk of patient selection and guarding against patient dependency may be mobilised to justify restricted GP complementary practice.

In effect, all these rhetorical claims mentioned above can be interpreted as a strategy whereby the GPs attempt to resolve or 'play down' the possible criticisms which may be directed towards further developing complementary medicine within the resource-starved NHS. Their claims would appear to represent useful rhetorical resources in the ongoing internal debates within general practice as to the appropriateness and worth of complementary integrative practice.

### 5.3.1 Styles of Complementary Medicine: Highlighting 'Quick' Treatments

The reality is that they are very difficult in the ten minute consultation, it's very difficult to use them as effectively as one might want to. The only complementary therapy I can talk about is homeopathy 'cause that's the only one I use erm, there is a way of doing, of using homeopathy in a sort of quick consultation style, you know you give the remedy off the top of your head, well not off the top of your head but you can ask a few questions and make a good guess at the remedy that might be good for the patient.<sup>44</sup>

If you were to do complementary therapies thoroughly it would take up to 40 minutes which you can't do in general practice.<sup>45</sup>

As explained so far in this chapter, the doctors tend to characterise complementary therapies as time consuming and highlight the extra time needed to practice such techniques. However, there is also another portrayal of complementary medical practice found in the accounts, one which emphasises the possibility of quick treatments suitable to the general practice surgery.

The three quotes below provide examples of this theme. The first is from an interview with a GP hypnotherapist. She says:

on the whole I don't use particularly deep hypnotic techniques. I use a lot of hypnotic shortcuts and I don't do any of the fancy things like age regression, that's not true I do go into age regression but I don't go into previous incarnations.<sup>46</sup>

And another GP practising hypnotherapy expresses a similar feature of his practice:

It used to take ages and that was a problem. I changed the type of people I was treating and I dumped one or two difficult ones, one or two difficult things that I found were taking a long time but then I got better at it and I found that in fact you could use hypnosis as you were explaining to the patient so you take minutes off the time but then I got better and I discovered that hypnosis takes two minutes and hypnosis is the one I use more of in general practice.<sup>47</sup>

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<sup>44</sup> Dr 9.

<sup>45</sup> Dr 8.

<sup>46</sup> Dr 10.

<sup>47</sup> Dr 4.

Meanwhile Dr 11 explains how ‘acute red neck’ is a condition he usually treats with acupuncture because of the speed of the technique:

I use it a lot for acute red neck, so if you came in the middle of my surgery with a torticollis and said god its horrendous I can’t move it and I would there and then a couple of needles in it and you’d probably go out saying oh that’s brilliant, it’s a good one to treat that because it’s acute.<sup>48</sup>

As all the quotes above illustrate these doctors do not appear to rule out lengthy treatments yet they focus the presentation of *their* complementary therapies upon conditions which are relatively quick and therefore considered appropriate to general practice. Talk of a rapid style of treatments is also common amongst GP homeopaths. Below Dr 12 explains how shorter homeopathic consultations can be accomplished:

If a patient comes in and tells me that their joint, they can predict when thunderstorms are going to come along because their joints suddenly worsen you know, that’s a very important homeopathic remedy, there’s only ten remedies that that applies to so I mean you can narrow it down. If they come in with a specific symptom that’s quite strange well you know you’ve only limited things to ask, sort of homeopathic medicine can give for that but it’s patients say things you listen to it and you think ah that’s a classic homeopathic symptom maybe you should try this.<sup>49</sup>

Similarly the following GP outlines how he employs a quick ‘first-aid kit’ style homeopathy which avoids meticulously tailoring the remedy to the particular characteristics of the patient:

I am not always using homeopathy in the formal type stylised setting. Mostly that’s not how I do it at all. Mostly I do it, it’s somebody that I know likes to use homeopathy and I really already know a lot about them and they’ve got aching joints and I’ll give them rhus tox because rhus tox is great for aching joints without being specifically great for them. So that, yes I will use it as a first aid kit.<sup>50</sup>

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<sup>48</sup> Dr 11.

<sup>49</sup> Dr 12.

<sup>50</sup> Dr 10.

This presentation is further illustrated in the following quote from Dr 8:

you do get sort of horses for courses and remedies for conditions as well, there's no question. It's not as pure as the driven snow and you will get remedies that are good for certain conditions, or three or four remedies which, all catarrh conditions will respond to one of these four remedies by and large, or all cases of PMT you can pick out three remedies and you can say that'll cover 80% of PMT in those patients. So you give 'em one of these three most likely. The same way chronic rheumatic conditions you can pick out again just three or four and the vast majority of people, there's one that will cure almost 60% not cure but relieve, so they do fall into categories as well for rheumatic remedies, and headache remedies and catarrh remedies.<sup>51</sup>

And GP 3 also makes a similar claim:

I use homeopathy fairly regularly because there is the acute prescribing for homeopathy which, I mean, infant colic OK try it with some [...] if that doesn't work we'll think again. Teething OK let's try some chamomillo. That to some extent can be quite preset but that's not, a purist would say that's not homeopathy that's using homeopathic preparations in an allopathic fashion, that's saying here's a condition treat it with that.<sup>52</sup>

The last two extracts highlight the link between these quick-style treatments as described by the doctors and some of the GP/lay therapy boundary work discussed in chapter four. Both Dr 8 and Dr 3 above acknowledge that the acute prescribing style of homeopathy which they so readily endorse fails to attract similar support from lay therapists.

### 5.3.2 Certain Medical Problems

Alongside and often intertwined with this talk of 'quick-style' treatments is also talk of specific medical problems which can be treated effectively using complementary therapies. For example Dr 10 explains how time leads him to restrict his use of hypnotherapy to certain cases:

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<sup>51</sup> Dr 8. This same doctor illustrates how this style of homeopathy may fit to certain conditions when he says: 'you see a patient come up with an acute condition, an acute viral infection or something ah, well there's a homeopathic remedy for that off you go. Prickly heat, hayfever, acute muscular skeletal things, homeopathy treats things like that'.

<sup>52</sup> Dr 3.

at first in general practice I used [hypnotherapy] for a wide variety of things. I used it for bed wetting, asthma and skin conditions and those were my three main ones and I resisted the weight loss and the smoking and things like that and I still do resist them I don't really have anything to do with them.

Interviewer: what's the reason for that?

Well the reason for that is it was that time, smoking cessation and the weight loss were almost a commercial venture in hypnosis and they took a lot of time and they took a lot of sessions.<sup>53</sup>

Dr 12 outlines how he uses his acupuncture:

Acupuncture. It's mainly pain control OK. So that's joint problems or muscle spasm, chronic pain, but it's quite limited what I'd use it for I mean the WHO have a list as long as your arm for things that possibly acupuncture can be used for but it's mainly pain control that I use it for.<sup>54</sup>

Below Dr 23 outlines how he limits his acupuncture in practice:

I tend to go for ones that are more straight forward and that I know have a high chance of success with acupuncture. Those, I mean mainly muscular conditions, people where there's a lot of underlying arthritis I tend not to be so keen to treat them because I know that we will only get partial success and there's also a chance that they will want treatment long term which is from my point of view means other people are not going to get the chance of treatment if they are blocking an acupuncture appointment.<sup>55</sup>

Here we have evidence of a particular rhetorical claim: because of the pressure of time the doctor suggests he only treats those cases that he knows will provide success. In this sense, there is a suggestion of a lack of risk and experimentation governing his decisions to embark upon acupuncture treatment.

All the quotes above provide further support for a piecemeal integration of unconventional therapies in general practice. Moreover, this talk, similar to a number of other descriptions in the accounts, helps portray general practice as a flexible form

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<sup>53</sup> Dr 10.

<sup>54</sup> Dr 12.

<sup>55</sup> Dr 23.



of medical practice, one which adopts selected techniques from a whole range of medicines on the basis of their suitability and effectiveness rather than slavishly following the line of one particular system of medicine at the expense of others.

Furthermore, these claims of limiting the use of therapies to a selective number of medical problems may prove attractive to other GPs not yet actively embarking upon integrative practice; this style of argument suggests incorporation does not necessarily have to entail extensive revisions in current practice behaviour nor an over-lengthy education and training in other therapies required to apply treatment methods to a wide range of medical problems.

As we shall see shortly, this selection of medical cases due to time constraints is supplemented in the accounts by another important consideration. Not only do these GPs suggest that complementary practice can be restricted to certain medical problems so as to fit more comfortably within general practice but, as will be shown in section 5.4 of this chapter, the doctors also claim that these selected conditions are the very medical problems which conventional medicine finds difficult to treat.

### **5.3.3 Patient Selection and Avoiding Dependency**

I'm very restrictive on who I do acupuncture on simply because of the amount of time I have devoted to it. So I don't advertise the fact that there's an acupuncture clinic here and I don't allow people to book into my clinic themselves without first having discussed it with me or having had their doctor discuss it with me.<sup>56</sup>

The previous section reveals the positive selection of patients with conditions that will respond quickly to unconventional treatments. In contrast, this section outlines how some of the GPs also appeal to the negative exclusion from unconventional treatments of those patients who are identified as having dependent

personality types. Again, this links to authentication processes in that the doctors suggest that because they know their patients well this selection of appropriate patients is aided. As will be seen, this talk of dependency and of selecting complementary medical cases based on patient type runs parallel to both the 'quick style' therapy and restrictive case selection.

Patient selection is presented by some GPs as the sole domain of the doctor him - or herself. Dr 19 expresses this fear of dependency:

people are never, are never given the chance of initiating it themselves. There probably are people who are very keen on acupuncture who would be keen to get it but they're not really given the opportunity to express that. I think occasionally by chance I'll offer it somebody who by chance is very keen but there's not much of an opportunity for people to do that really. In fact, I would prefer to have people who weren't terribly devoted to acupuncture because the people who are very, very devoted would tend to keep coming back and wanting it again for other problems and that would kind of swamp me.<sup>57</sup>

Here the GP outlines a fear of 'being swamped' by the increasing demand of patients that are devoted to acupuncture, and describes how as a result he denies patients the opportunity to initiate complementary treatment. We can see in this quote how the GP clearly employs the notion of patient type as a means of justifying the restriction of his therapy to his patients. This is an interesting presentation and one which may work to bolster the imagery of general practice as a pragmatic and flexible branch of medicine which was identified in chapter four. In the quote above the GP appears to favour those patients not devoted to one type of medicine as the preferred patient type for his acupuncture treatment. Again, notions of piecemeal and pragmatic complementary practice are promoted - using the therapies alongside more conventional techniques as one part of a wider pluralistic healthcare approach responsive to differing patient beliefs and perspectives.

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<sup>56</sup> Dr 19.

Another GP outlines a similar concern about his acupuncture treatment. Here he directly employs a rhetoric of dependency as a means of justifying the restrictive approach to practising acupuncture in his surgery:

If I'm treating a lot of people who've got psychological reasons for psychosomatic illnesses they could very quickly become dependent on me. Now if I'm running a private acupuncture clinic I don't mind if someone becomes dependent upon me because that's great they're paying me. If I'm a GP and my only constraint is the time that I've got to spend on something, if I've got Mrs Jones coming every week for two years for acupuncture just for lots of different things then that's not good for me because I get bored of seeing the same person every week and I'm not helping a lot of other people so that becomes, that's not possible.<sup>58</sup>

Like GP 19, Dr 12 above quite explicitly draws upon an idea of patient type as a justification for restricting complementary interventions. Moreover, the talk above helps distance integrative GP practice from a more indulgent style of private lay practice in line with the GPs' claims examined in chapter four. The notion of patient type is taken a step further in the following quote by Dr 2:

you can choose the patients that you want to do it with. You can choose the ones that you think, you see in acupuncture, in our general practice you generally know the headbangers and with these sorts of patients there's no way that most GPs would ever want to get involved in anything but straightforward medicine. It's what we call a heart-sink patient you know if you cure their sore knee they come back with headaches, you cure their headaches they'll come back with dyspepsia, you cure that they'll come back with something else.<sup>59</sup>

Here the repertoire of the heart-sink patient is employed as a means of highlighting problems of dependency. As will be seen a little later some other GPs draw upon this patient classification in a different way, primarily as a means of illustrating the positive contribution of complementary therapies to their general practice.

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<sup>57</sup> Dr 19.

<sup>58</sup> Dr 12.

<sup>59</sup> Dr 2.

## 5.4 Filling Gaps: When Orthodox Treatments Fail

I think you can expand it and use it as an adjunct to western medicine to treat a lot, a wider range of things but I would never see acupuncture as being a whole system by itself, erm, certainly the way I use it is purely as an adjunct to other, to western medicine.<sup>60</sup>

[T]hey give me more skills to use when standard allopathic medicine has nothing to offer sort of thing, you know, they are complementary, if allopathic medicine doesn't work then there are other therapies to try...I think I could use it an awful lot more but where I use it is for people mainly who've tried allopathic medicine and they're kind of at their wits end and you've got to think of another therapy.<sup>61</sup>

[B]ecause I'm using it as a complementary therapy I tend to say to people look we've tried everything else you're no better how about we look at homeopathy and see if there's anything there for you. I tend to use it where allopathy failed that's the guiding rule. If I can I can use orthodox procedures which are recognised and easily available I'll use them if the orthodox procedures are not easily available then in the mean time I might try something else. That's basically it.<sup>62</sup>

[S]ometimes you'll start off the treatment with people who you'll maybe think you know nothing's working for you and I'm aware of the fact that this is a last gasp attempt.<sup>63</sup>

I thought [acupuncture's] quite interesting because there's quite a lot of things we're not very good at treating, headaches, back pain, that sort of thing, so that's when I got interested.<sup>64</sup>

As section four in this chapter shows most of the GPs are keen to present their complementary therapy as restricted to a number of particular medical problems. This limited scope of practice is partly justified through an appeal to the pressure of time (in addition to some of the rhetorical claims laid out in chapter four referring to the dangers of 'alternative' style practice). However, the GPs also employ another quite different device in their attempt to appropriate a 'restricted' integration of complementary therapies into general practice; the doctors present complementary techniques as suitable 'gap fillers' providing possible solutions to medical problems which orthodox medicine fails to help. As this section illustrates in more detail this

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<sup>60</sup> Dr 19.

<sup>61</sup> Dr 12.

<sup>62</sup> Dr 3.

<sup>63</sup> Dr 11.

<sup>64</sup> Dr 24.

portrayal of the role of other medicines is a potentially powerful rhetorical device with which to claim suitability and worth for their practice of the therapies to colleagues.

Below Dr 12 suggests that 'complementary use' is itself a response to the pressures of time:

most of the time where I would use both allopathic or both homeopathic and acupuncture is when they have tried the standard therapies and they haven't worked because they're more time consuming. I have to ration how much homeopathy and acupuncture I can use. Standard therapy is much easier and if it works well and good, if it doesn't work then I'll think of another model.<sup>65</sup>

And elsewhere in his talk this same GP again presents time constraints as linked to extending treatment options for those patients who have tried standard treatment:

time is a big thing because you spend more time with them. I think that you're a better listener you know that you don't sort of pigeon hole people and say well look I've only got this drug for you if that doesn't work then I've nothing more to offer you and that's it you know don't come back and see me I've nothing to offer you, so I think if you extend that and say well I'll have a few more other therapies to try these kind of you know the patient will perceive that you've done your best and that you extended yourself a bit more and you've tried a few other things.<sup>66</sup>

Here the doctor also employs another powerful rhetoric which is common across the accounts. He claims that integration is patient-friendly; patients appreciate the range of options - this helps present direct integrative practice as patient-centred with the GP seeking new solutions with a view to patient well-being. Such talk provides further evidence of the GPs' use of a non-contingent repertoire to describe their practice; in this particular case above direct integrative practice is employed to further enhance claims that general practice is directed by the interests of patients rather than the profession itself.

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<sup>65</sup> Dr 12.

<sup>66</sup> Dr 12.

Dr 4 provides a good example of how many of the doctors portray complementary therapies as an add-on, an adjunct to standard therapy. He puts it like this:

they're just different models of health care you know sort of I don't know how you would do it percentage wise but maybe allopathic medicine might cure 20% of illnesses and you're adding another 5% homeopathic wise, another 5% acupuncture wise and then manipulation 2% so that's all, as opposed to being stuck at that 20% you're always looking at ways to try and increase.<sup>67</sup>

And Dr 8 says of his homeopathy:

classically it would be for someone who presents with a condition which is being treated or is being treated but inadequately and I'll say ah well let's just look at this and if you see a homeopathic pattern emerging say right here's the very remedy for you, take this as well or instead of what you're getting.<sup>68</sup>

While this role of secondary treatment for unconventional medicine is common across all the accounts, some GPs do suggest that with practice experience they may in some cases promote their therapy to the first line of treatment (after conventional diagnosis). However, the GPs suggest that these cases are the exception; they are only possible given a depth of knowledge of the remedy from repeated usage. As Dr 23 explains his practice of acupuncture:

I use it more for pain relief. I find it useful with people who have conditions that either haven't responded to conventional medicine or perhaps they don't want to take conventional medication or they have a condition where I feel it might respond better to acupuncture than conventional medication. For instance people with migraine headaches erm, you know I find personally that treating it with acupuncture is often much more successful in giving people long term relief than giving them tablets, and I'm more likely to offer them acupuncture before even tablets in some cases.<sup>69</sup>

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<sup>67</sup> Dr 4.

<sup>68</sup> Dr 8. Dr 23 suggests his referrals for homeopathy can be employed in a similar way - as a last effort to find a solution to certain medical problems after conventional therapy has failed to help: 'In the vast majority of cases it's very often been for things like eczema, insomnia and recurrent urinary problems. Patients have tried conventional treatments which has not helped and they had conditions that I thought might benefit from homeopathy because I know from the past these conditions have helped'.

<sup>69</sup> Dr 23. This same doctor also provides another example of this rhetorical construction. Here he again explains how his decision to practice acupuncture is sometimes in response to the failings of



This same doctor also outlines how the role of acupuncture is often bound to ongoing problems that conventional medicine has failed to treat adequately:

I would mention it and say well acupuncture is a possibility, if you like we'll try such and such first of all and if we find that doesn't work then have a think about it and you know very often they will come back and say well I'd like to try it 'cause I'm so desperate. I mean they've often tried everything else for some people it is the last resort because everything else has failed.<sup>70</sup>

Examining this last quote we can once more detect an implication in the GPs' talk that the integrative treatments are in line with patient demand and strengthen patient-centred practice. This talk provides yet another example of the way in which these GPs convey their medical practice as led by patient interests and therefore as void of professional self-interest.

In some of the GPs' talk the supplementary role for complementary medicines is presented as a possible reason for why therapies might not always be effective. As Dr 18 states, 'I don't necessarily feel disappointed if treatments don't work because I always feel a lot of patients it is a last resort treatment for most of them'.<sup>71</sup> Dr 24 provides a similar account of his use of acupuncture. In this case he draws upon the category of the heart-sink patient as a means of justifying why complementary therapy may not always be successful and why it can be frustrating in many cases. He says:

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conventional treatment or the unsuitable reaction of the patients to certain drugs. Furthermore, he suggests there are instances in which acupuncture may be moved forward in the treatment plan or elevated higher in the hierarchy of treatment solutions. In the extract that follows this is portrayed as dependent upon the patient being a good responder. He puts it in the following way: 'I'm not actually sure that I could clarify what makes me decide that somebody should get acupuncture. Sometimes it's just people have tried conventional treatments from other partners and obviously things haven't worked or the medication's disagreeing and then we try the acupuncture or if I have somebody I know has had acupuncture before for a different condition and has responded really well, if they're a good responder then I'm likely to give them treatment at an earlier stage in their illness'.

<sup>70</sup> Dr 23.

<sup>71</sup> Dr 18. Dr 3 outlines the same point in relation to his homeopathy: 'you tend not to treat patients with homeopathy, you tend to treat them with homeopathy after allopathy has failed so when homeopathy doesn't work they say oh homeopathy's useless but in fact they're trying it on the hard core cases which we don't have cures for anyway so it's really not fair'. Dr 3.



Basically although it's a nice additional armamentarium and I enjoy that sometimes the negatives of using acupuncture are quite deflating because it's often time consuming if it doesn't work and also it's occasionally you're dealing with our heart sink population. There's probably more heart sink patients get acupuncture than anyone else.

Interviewer: why is that?

I think that's because a lot of the time when you get to using acupuncture something you are thinking about what are the other options for this patient, you know, you maybe have tried lots of other things and you're not getting anywhere...but basically they still have that pain in their back doc and so you go for acupuncture and you try it and all the time in the back of your mind you're hoping it does work but you might not be surprised if they walk out after four or five sessions and the back pain's not any better.<sup>72</sup>

This focus upon the potential difficulties of developing effective complementary therapies may prove to be a useful cushion for these GPs if faced with anecdotal or one-off cases where complementary treatment has failed. As these quotes show the therapy itself is protected from such criticism by appealing to the complex and challenging nature of the medical complaints involved.

Dr 3 talks of the failure of conventional medicine to treat certain medical conditions when explaining his practice of homeopathy and hypnotherapy in the case of chronic pain. Here we can detect how the GP also draws upon the repertoire of 'time constraint' in relation to these therapeutic options. As he puts it:

chronic pain for whatever cause is a classical one and that the complementaries do help with, you can use homeopathy and you can also teach them hypnotherapeutically techniques for dealing with pain if you want to, if you want to invest the time. It's hell of a lot easier to prescribe a pain killer but I mean bad pain, post shingle pain these sorts of things there's no real treatment for.<sup>73</sup>

And Dr 8 says:

they keep coming in saying [conventional drugs are] not working, they're not working, they're upping the dose, the upping the intake you think where does

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<sup>72</sup> Dr 24.

<sup>73</sup> Dr 3.

this stop when they're on morphine? you know they keep coming in and you keep saying I can't give anything stronger I mean that's a dead end that's not a nice situation to be in so if you can move sideways you can say ah look why don't we try this.<sup>74</sup>

Dr 7 also portrays the role of his homeopathic therapy in terms of a supplementary role; filling gaps and providing possible solutions to medical problems which are otherwise beyond help. As this quote reveals the doctor employs this rhetorical claim as a direct means of illustrating the suitability of complementary therapies to general practice in her talk. She says:

I think [homeopathy] is suitable for general practice erm because a lot of the time you're giving out prescriptions that you know aren't going to do the patient any good anyway, cough bottles and standard things. I think there are an awful lot of conditions that are chronic that we really can't do an awful lot for, chronic back pain, erm, chronic catarrh, skin problems. I think you know I feel there's a potential there for homeopathy helping with some of these conditions.<sup>75</sup>

Dr 19 and Dr 4 both explain how acupuncture is more often than not administered as a last option of treatment - the therapy provides an extra weapon if other more conventional avenues of treatment have proved unsuccessful. Dr 19 says:

It provides me with an extra option in treating people, a lot of people come along and there really isn't any other option you can give them and acupuncture can be a new way of helping them, a different option, a different road to go down, so it's erm, extra kind of, extra weapon in your armamentarium for treating people.<sup>76</sup>

And Dr 4 puts it like this:

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<sup>74</sup> Dr 8.

<sup>75</sup> Dr 7. Dr 21 makes a related point when explaining the supplementary role of homeopathy and other therapies: 'Well I think just an acceptance that homeopathy like other forms of alternative medicine, that traditional guidelines and pharmacological drugs don't have all the answers and we can treat patients until we are blue in the face according to the guidelines and some of them won't get better so there has to be other strategies that can be tried'. And Dr 24 also states: 'the things I'm doing it for I know there is no good conventional treatment for. If you came with severe, if you were getting migraine there are good treatments now for migraine which involve just slipping a pill in your mouth. If on the other hand you were getting tension headaches and I'd say well no tablet apart from taking paracetamol, no tablet is very good for that so why not try this'. Dr 24.

<sup>76</sup> Dr 19.

these were all patients that had gone through the gamut of standard orthodox treatment had had surgery in some respects had had physiotherapy had had painkillers and were still suffering from the pain. I felt it was very justified to er, when everything else had been tried and then to go on to acupuncture as a next line.<sup>77</sup>

And this same GP (Dr 4) suggests that in many cases patients themselves prefer to receive conventional medicines as a first line of treatment:

I think you've always got to negotiate with the patient that you have in fact to be honest and tell them that in fact you're thinking of doing acupuncture before other more conventional treatment and ah most patients are still relatively conservative and I would think given the option most patients would still probably want to go for the conventional treatments.<sup>78</sup>

This style of argument helps the GPs justify a supplementary and additional role for complementary therapies. Again, as elsewhere in the accounts, patient expectations are highlighted as a means of defending piecemeal and restricted integration and as a means of presenting GP therapy as sensitive to patient demands and perceptions.

Some of the rhetorics examined thus far in this chapter highlight problems associated with orthodox medicine. The claim that conventional medicine still cannot provide cures and/or relief for many conditions (often chronic illness) has been a popular criticism (academic and consumer) and sometimes a means of justifying an experimentation with alternative health care. This rhetoric would also appear to be drawn upon by these GPs in their attempts to legitimate complementary practice to their surgeries.

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<sup>77</sup> Dr 4.

<sup>78</sup> Dr 4.

### 5.4.1 Mixing Caring with Curing: The Technical Fix of Complementary

#### Treatment

I think [complementary medicine] probably expands general practice

Interviewer: Can you explain that for me?

Well it's what I was doing before but it's sort of added to it. So it's like another, another set of tools that you didn't have before that suddenly a lot of things that were broken can be fixed now that you have the tools for them.<sup>79</sup>

In advocating a supplementary role for complementary therapies within their surgery the doctors describe how expanding their therapy skills can provide *possible* treatment options for those health care problems where conventional medicines fail to help. However, the kinds of justificatory rhetorics discussed so far in this chapter do not necessarily imply that complementary therapies can cure these selected medical cases, simply that they can provide another avenue of approach when all else has failed. The talk analysed earlier in this chapter makes no mention to notions of efficacy; instead, there is a suggestion that it is important to keep on trying some form of therapy, even if the benefit of that treatment for the patient is dubious. However, some of the GPs do talk of their complementary medicines as providing genuine solutions to otherwise untreatable presentations; those patients who were previously defined as problematic because they required countless consultations can now be reconceptualised as cases where complementary therapies prove effective. As one GP homeopath explains:

I thought more and more of the things that were coming in the door were things that I couldn't do a great deal with...quite often I saw people and just talked to them anyway. I sort of counselled people without giving them medicine anyway. I did, I have been doing that in general practice ever since I started. And so being able then to say yes I'll see you but I can give you something that'll make you better was great.<sup>80</sup>

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<sup>79</sup> Dr 6.

<sup>80</sup> Dr 20.

And another expresses a similar point:

something like sixty-percent of the patients that come in here have problems as a result of life circumstances more than anything and there's no conventional treatment for it, whereas the homeopathy gets right to it, you know. So it's treating patients that you've always wanted to treat but couldn't.<sup>81</sup>

Once again this talk projects an expansion of successful practice as a result of integration. More specifically, conventional treatments are here portrayed as unsuccessful in dealing with a particular class of illness - that which is classified by the GP as the result of factors in the social environment of the patient. As will be seen in the following chapter, this characterisation forms part of the rhetorical strategies developed by some of the GPs in relation to a particular professional identity and role.

These passages of GP talk above illustrate how complementary therapies may enable these GPs to mobilise an interventionist and heroic rhetoric of 'curing'. In accordance with this style of presentation Dr 4 practising acupuncture says:

it's such a natural way to take, er, if you're in general practice to go down the route of complementary therapies because they do offer the possibility of lots of relief of symptoms or even cures. In general practice there's so much that you see that is, that you cannot cure.<sup>82</sup>

This quote represents a lucid illustration of how this rhetoric of 'curing' can help authenticate complementary therapies within the general practice setting. The limitations of conventional medicines in terms of failing to deal with a particular range of illnesses and medical complaints has often been referred to in more formal medical literature<sup>83</sup> and it does seem likely that the possibility of expanding treatment choice and, even more significantly, increasing the rate of successful consultations

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<sup>81</sup> Dr 5.

<sup>82</sup> Dr 4.

<sup>83</sup> See Gabe, J., Keheller, D. and Williams, G. (eds) (1994). *Op. Cit. No.17*.

may prove to be tempting for other general practitioners who have yet to embark upon complementary practice or who are still to be persuaded of the worth of integration.

## 5.5 Positive Appeals to Efficiency

[Hypnotherapy] pays off in terms of more time with the patient less time later.<sup>84</sup>

You know, if you take it over a time-scale of ten to fifteen years and count up how often these people are at a surgery if you can deal with it in two sessions of hypnosis you're actually saving time at the end but it is difficult when the place is really busy to persuade partners that you're doing this, that there's a benefit.<sup>85</sup>

If you combine [conventional treatment] with something like neurolinguistics then you can do quite a lot of work in a very short time and I certainly have got some good sort of experiences not necessarily full blown hypnotherapy like keep the patient in an altered state of consciousness for an hour but actually very short consultations which went incredibly well and would not have gone so well had I not used those techniques like disassociation and stuff like that so it's something I would use a lot in my consultation where it's appropriate.<sup>86</sup>

One rather direct means of countering the potential difficulties of time management which accompany complementary practice is for some GPs to present complementary therapies as time saving. This is a claim which often fits alongside the rhetoric of cure and can act as a very useful strategy in terms of persuading not only colleagues but managers and cost auditors of the worth and appeal of integrative practice. Dr 1 draws upon this particular claim as a direct justification for initiating hypnotherapy in specific clinical circumstances. He claims:

I think it does have something different to offer. I think it may well be more effective and cost effective as well in certain situations than say traditional medical treatments you know it might be more effective to treat someone with a few sessions of hypnotherapy for their irritable bowel than go on taking pills without any major improvements in their condition over years and years and years.<sup>87</sup>

And Dr 17 claims with regard to his complementary medicine skills (hypnotherapy, neurolinguistic programming and autogenic training):

I can give them more time and certainly that aids the process if they've got a fairly complex social problem to resolve it's not that easy to do in ten minutes

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<sup>84</sup> Dr 10.

<sup>85</sup> Dr 5.

<sup>86</sup> Dr 14.

<sup>87</sup> Dr 1.



but if I can use my complementary medicine skills to help them appreciate what I think is probably going on in their life and give them some insight into the dynamics of their own situation then that is very useful for them and it might save a lot of work in the future.<sup>88</sup>

In this quote the GP suggests that time may be saved in the long run through complementary therapies providing some self-realisation on the part of the patient.

Dr 3 outlines how he sees his hypnosis and homeopathy as possibly freeing up time in the long run. He says:

I may think this patient is using a lot of our time coming in frequently with the same complaint, we're not curing it, the patient's not satisfied, we're not satisfied so let's try once and for all and invest a couple of hours and see if we can really deal with it.<sup>89</sup>

With reference to a particular medical case Dr 14 employs a similar argument:

I had a chap who when he went to the doctor it reminded him of his dad's brain tumour and it's because he's got something in his brain that he associates with something that upset his father and in fact he didn't know the association was there until we actually brought it out and actually talked around it and eventually we got that the guy blamed himself for his dad dying which of course is nonsense, the man would have died anyway

Interviewer: Can you deal with that without the hypnotherapy or NLP?

No. I would think, if you're asking me I would have dealt with it quite well before I think what it has allowed me to do is to deal with it better. I don't think there was ever a time when I wouldn't be able to get, but it would have taken me longer.

Interviewer: Can you explain that?

Because I can pick up signals and that. I can pick up things that people say because I know I've done the neurolinguistics and stuff and I'll understand more quickly what they mean and I can actually pick out the relevant things. I can combine it with things like whether they're operating in different modalities like kinaesthetic or something like that or visual or auditory and actually home in on the thing that I think is gonna work, that is perhaps gonna do the job.<sup>90</sup>

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<sup>88</sup> Dr 17.

<sup>89</sup> Dr 3.

<sup>90</sup> Dr 14.

This GP suggests her practice of neurolinguistic training and hypnotherapy provides skills which she can utilise to make certain consultations more time efficient.

Later in this interview the same GP (Dr 14) employs the rhetoric of cost as a means of appropriating her complementary practice. She says: 'I know that I can prove that these patients have reduced their consultation dependency in the surgery so essentially I can also prove therefore there's a cost saving to this and that's sort of traditional stuff that people want to know, the scientists, the public health people'.<sup>91</sup> Once again, as seen in earlier sections of this chapter, talk of cost saving is here presented as an off-shoot of the time reduction produced through incorporating unconventional therapies into the GP's surgery.

Talk of the initial time investment involved in complementary therapies will certainly fail to arouse enthusiasm from those GPs who are not currently developing the medicines in their practice, and it may act as a continuing barrier to the further integration of the therapies within general practice. However, the claims that integrative practice can save both time and costs in the longer period may prove to be a very strong attraction, especially to those involved in the purchasing and management of health care, and may encourage more widespread integration within general practice.

## 5.6 Safety: Side-Effect Free Treatments

I think for me its a very very safe treatment.<sup>92</sup>

Homeopathy is side-effect free. I think that's the big difference with conventional medicine, you're always thinking, you know, what side-effects are going to happen here and obviously you don't share all the side-effects with patients you just keep that to yourself and hope it never happens whereas with homeopathy you know that there aren't going to be any side-effects because you're not really giving very much, so that's a different approach really. I think it's actually just seeing that medicine has got limitations and side-effects. I think it's the, the more you practise medicine the more side-effects you will see and the more horrendous side-effects you see and I think that's what makes you very weary of conventional medicine.<sup>93</sup>

The big benefit is it's not harmful at all you know.<sup>94</sup>

[T]he thing about your orthodox medicine is that you're seeing all the time more and more iatrogenic effects, your more and more side effects from drugs and harmful effects from drugs and you know I think that makes you look at something else, you know there must be more.<sup>95</sup>

Earlier in this chapter it was shown how some of the GPs appeal to the limitations of conventional treatments as a means of making space for complementary therapies within the boundaries of general practice. Another limitation to modern conventional medicine which has attracted considerable attention from writers and medics alike is the possible side-effects of high-technology and drug-based treatments. Interestingly, such talk of the side-effects of conventional medicines is common within the accounts of my GPs and is accompanied by contrasting descriptions of unconventional therapies as safe, natural and non-invasive techniques - all rhetorics popular amongst protagonists of the therapies more generally.<sup>96</sup> This section illustrates how the doctors employ these contrasting images of safety and

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<sup>91</sup> Dr 14.

<sup>92</sup> Dr 11.

<sup>93</sup> Dr 20.

<sup>94</sup> Dr 13.

<sup>95</sup> Dr 7.

<sup>96</sup> See West, R. and Inglis, B. (1983). 'If the Mind is Fit, the Body Will Cure Itself'. *The Times* 8 August: 6. Douglas, M. (1994). *Op. Cit.* No.17.

danger as a means of legitimating their decision to integrate complementary therapies into their practice.

Dr 12 explains his concerns regarding the dangers of conventional treatments:

I think a lot of our drug therapies you know they say 30% of patients are in hospital because of iatrogenic illness you know so I think you've got to give something that's not going to harm the patient. Homeopathic remedies don't effectively have side-effects, you're giving such a small dose you know you can get aggravations and things but if you stop the medication that stops, that's supposed to be therapeutic because that's the right remedy.<sup>97</sup>

In this example, the GP refers to the 'small dose' of homeopathy as a means of highlighting the relative safety of the therapy.<sup>98</sup> This same doctor later returns to similar rhetorics, this time talking of creating antibody resistance in the community:

so much of what we do, you know, sort of questions of whether or not to prescribe antibiotics for viral things because you don't want to build up resistance in the community. The patients want something for their illness, such people are very disillusioned when you say you've got nothing to offer them just take your paracetamol. So you say well try this homeopathic remedy this works on some people that in itself is not doing any harm you're not creating antibody resistance in the community.<sup>99</sup>

This quote also illustrates how notions of patient demand and expectations are drawn upon by some of the GPs as a means of supporting their own concerns with side-effects. The patients, it is claimed, expect some form of intervention (even if the

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<sup>97</sup> Dr 12. Dr 16, like some other GPs, also highlights the fact that complementary therapies are not drug-based. He says, 'I think in general practice as opposed to any practice, it's just an extra tool that isn't drug-based'.

<sup>98</sup> Other GP homeopaths draw upon this same rhetoric of 'small doses' in the remedies as a means of illuminating the potential safety of the therapy. As Dr 20 says, 'having the fact that powders and tiny tablets which obviously contained very little could bring about cure was quite interesting and the fact that it was side-effect free. I'm very aware that a lot of the other things that you've been using to treat, for both these things either steroids or certainly for the eczema and you're always aware of the side-effects of them'; and Dr 11 claims, 'you use arsenic as one of the therapies in such *minute doses* that it really it doesn't give you side-effects to the same extent and I think there's a few of them in conventional medicine, there's no doubt the majority of the tablets that we use can potentially cause harm'.

<sup>99</sup> Dr 12. This GP outlines these themes in another section of his talk when he says: 'there's no doubt [homeopathy] is an effective therapy and there's no doubt that people can help themselves and if someone has the flu and you don't want them taking sixteen paracetamol a day which they can end up doing with them taking their Beecham's hot lemon and their Anadin and something else and poison

doctor does not necessarily think it appropriate) and faced with this patient pressure the safety of treatment is paramount.

Other GPs in the study illustrate this concern with safety and complementary medicine in terms of specific patient populations who are deemed particularly susceptible to the dangers of drug treatments. For example Dr 3 states:

I use homeopathy a lot for kids where you don't want necessarily to have big doses of paracetamol or lots of recurring antibiotics

Interviewer: that's important then?

The side-effect of medicines, the safety angle aha.<sup>100</sup>

While this doctor concentrates her talk upon younger patients, in contrast Dr 25 employs similar rhetorics with regard to her elderly patients:

if someone wants a treatment for a self-limiting illness it's hell of a lot safer to give them a complementary treatment than send them away with antibiotics and a cough bottle that if they're old might end up causing urinary retention or something.<sup>101</sup>

GPs practising other therapies apart from homeopathy also promote a 'safety' and 'side-effect free' rhetoric when talking about their integrative treatments. For example, Dr 14 contrasts his hypnotherapy with certain conventional drugs such as nonsteroidals in the following way:

if you give somebody nonsteroidals and they die you think well you know that's a side-effect of it but it's not really you know, it's a major problem for the family and who's left and all the rest of it. So if I can avoid doing something like that I can give give some hypnotherapy to perhaps control their pain really I don't care how it works as long as there's things I want to be reassured about and one is that I'm not going to do that patient any harm. I think that's crucial.<sup>102</sup>

Practising acupuncture Dr 2 presents the therapy as below:

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themselves. So I mean if they're taking homeopathic remedies that's fine so you prefer people in the community doing something that at least won't do them any harm'.

<sup>100</sup> Dr 3.

<sup>101</sup> Dr 25.

acupuncture for me is an alternative medicine which has no side-effects, it doesn't bring you out in rashes and there's nothing to be lost there's no harm in it there's no danger in it and I take a very laid back approach. I say to the patient all right give it a whirl and see how you get on. I feel that's how I've come to terms with acupuncture, to say that I know it doesn't do any harm. I know I'm not doing any harm. It means to me it's something else that I can do to help my patients which is not conventional medicine which I'm happy to do which is no risk.<sup>103</sup>

And Dr 7 explains how homeopathy can be seen as a suitably harmless treatment to prescribe in situations where conventional medicine has nothing to offer:

you know there are an awful lot of things that we can't do a lot for anyway and you're as well giving a homeopathic preparation which isn't going to harm them than give them other things which don't always help and which have side-effects.<sup>104</sup>

This presentation projects a role for homeopathy which is quite clearly that of a supplementary treatment. While homeopathy is not necessarily beneficial to the patient, it may be employed primarily as a cautious intervention which minimises clinical risk; complementary therapies are presented as a safe option yet ultimately as a subordinate technique to conventional medicine.

Some GPs talk of the non-invasive nature of the therapies.<sup>105</sup> For example Dr

10 describes his acupuncture consultations and their significance as follows:

On the whole what happens is you come in for your acupuncture you get it it takes ten minutes you go away and you don't take tablets so in fact it

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<sup>102</sup> Dr 14.

<sup>103</sup> Dr 2. Other GP acupuncturists also employ such discursive constructions. Dr 4 says, 'you can't say it's definitely going to work with any medication you can't say it with acupuncture but you can hopefully say well I think this might do you some good and the prospect of good is a lot greater than the prospect of any harm'.

<sup>104</sup> Dr 7. Dr 21 projects a similar role for his homeopathic remedies. Again, the relative safety of homeopathy is linked to gap filling: the therapy is suitable due to its safety in cases where conventional treatments are inappropriate. The GP puts it like this, 'I think there are certainly areas where traditional materia medica doesn't have the answer and there are also areas where traditional materia medica has the answer but a lot of side-effects and homeopathic remedies are safe. The worse that can happen is that they'll not be any better but they'll certainly not be any worse and there'll be no side-effects. Dr 21.

<sup>105</sup> A similar rhetoric is employed by some social science commentators to describe unconventional medicines. For example see Salmon, J. W. and Berliner, H. S. (1980). 'Health Policy Implications of the Holistic Health Movement'. *Journal of Health Politics, Policy and Law* 5(3): 535-553.



minimises the problem. It, although you're getting quite an active hands-on treatment it's not high tech and it's so, it lessens the medicalisation you know if that's even a word

Interviewer: aha, can you explain that?

you know it makes it less. It makes it more important and the patient's being taken seriously and I think they like that. I mean people do like it if they have a complaint for it to be taken seriously and acknowledged their complaint the full. You've offered them what you have and yet at the same time you've diminished its importance as a disease. So very often they can move on from you know, I don't really think I've used acupuncture for somebody who's a cardiac cripple but you know you very often do get some people who become cripples because of the diagnosis not because of what their disease is doing to them. Have had a heart attack, oh dear me, give up work, give up everything you know instead of I've had a heart attack my goodness this is a warning, I'll just get on with my life and do everything I want to do.<sup>106</sup>

Once again the talk introduces notions of patient expectations. The GP suggests acupuncture may reduce the patient's problem simply through taking their complaints seriously - something that patients do expect from their doctor.

Linked to this talk of safety is a more explicit description of complementary therapies as natural:

complementary medicine is more *natural* essentially you know I think that we've got very many very useful drugs but the patient has got very many techniques to get themselves better and I am also a drug and I'm not saying I use myself in that way but I think that depending on the doctor's approach and rapport with the patient then you can be a very powerful force for healing and the patient themselves can be a very powerful force for healing if you encourage them to think along those lines.<sup>107</sup>

This GP directly employs the rhetoric of 'natural' therapy which is often drawn upon by non-medically qualified practitioners and others.<sup>108</sup> In this quote the doctor

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<sup>106</sup> Dr 10.

<sup>107</sup> Dr 17.

<sup>108</sup> For discussion of therapists perceptions, see Cant, S. & Calnan, M. (1991). *Op. Cit. No. 16*. Other commentators have also raised this point, see Dickinson, P. S. (1996). 'The Growth of Complementary Therapy: A Consumer-led Boom'. In E. Ernst (ed.). *Complementary Medicine: An Objective Appraisal*. Oxford, Butterworth-Heinemann. Atkinson, P. (1978). 'From Honey to Vinegar: Levi-Strauss in Vermont'. In P. Morley and R. Wallis (eds). *Culture and Curing: Anthropological Perspectives on Traditional Medical Beliefs and Practices*. London, Peter Owen.



mentions the powerful force of doctors and patients for healing: forces which he suggests complementary therapies are sensitive to and actively encourage.

Some of the GPs locate their focus upon safety and side-effects within the general practice community more generally:

I think it's a healthy concern. I would hope that it's the same concern that all my GP colleagues have. I wouldn't regard myself as different from any of, I think that if you're a decent GP you are aware that every medication has its down side and I think it's the same way now we try not to give antibiotics at the drop of a hat.<sup>109</sup>

This talk helps further justify the integration of complementary therapies in as much as it portrays the concern with side-effects as a natural component of being a decent GP. Worries about and consequently attempts to counter-act problems of side-effects through integrating the practice of complementary therapies are authenticated and located firmly within the professional concerns of general practice. In effect, these concerns - which are elsewhere linked by the GPs to the practice of other therapies - are contextualised in terms of the wider concerns of the profession more generally and therefore help naturalise and justify the motivation for integration if not the actual complementary practice itself as a normal feature of general practice.

Another common feature across many of the GPs' accounts is the employment of the concept of the safety of complementary medicine as a means of practising a patient-centred approach. In these cases the doctors contextualise their attempts to reduce harmful side-effects in terms of similar patient-demands and concerns.<sup>110</sup> For example Dr 21 says:

I'm certainly aware that there is an increasing interest in patients who are you know concerned about traditional drugs and side-effects and long term safety, erm, they are keen to do it so I am there to meet their needs. One of the cases

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<sup>109</sup> Dr 11.

<sup>110</sup> As Dr 20 states, 'I think the big attraction for patients is saying to people I can give you this. It will certainly never do any harm, it's safe, it's side-effect free'.

that comes to mind is erm, in cases of a lot of babies who have colic. I prescribe homeopathic remedies for that and it seems to work quite well and the mothers are particularly keen on something that they know is safe to take.<sup>111</sup>

Dr 24 practising acupuncture also combines these rhetorics of safety and public demand when he says, 'it's fairly easy it doesn't involve pills and actually many of the public are not keen on taking tablets if there's an alternative'.<sup>112</sup> Another GP illustrates the use of a similar rhetorical device in his talk of acupuncture treatment:

patients come in and they've heard I do homeopathy and they say I think I'm getting side-effects from this tablet for my arthritis or whatever so I say well we could you know we could try homeopathy and they go oh that would be quite good cause I don't really like taking all these pills.<sup>113</sup>

And Dr 11 explains:

you use arsenic as one of the therapies in such minute doses that it really it doesn't give you side-effects to the same extent and I think there's a few of them in conventional medicine there's no doubt the majority of the tablets that we use can potentially cause harm and we do have a situation often when patients come in expecting something and it's nice to have a few extra things to use to give people, maybe that placebo push or whatever else that you're actually handing over, something that's maybe benefiting them but also undoubtedly is doing them no harm.<sup>114</sup>

All these extracts from GPs' talk which portray a link between patient expectations and the doctor's own concern with safety issues tend to substantiate the legitimacy of complementary treatment; if it can be argued that patient perceptions and concerns are themselves authentic features to be considered when prescribing, then complementary therapies can be seen to provide a useful role in practice, even if this is only to appease certain patients. Here once again, as with certain points in the analysis of talk presented in chapter four, the GPs appeal to the imagery of patient-interest to portray their medical approach and practices in non-contingent terms; the

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<sup>111</sup> Dr 21.

<sup>112</sup> Dr 24.

integration of unconventional medicines is justified via a claim to the needs and demands of patients thereby helping present complementary general practice as patient-centred medicine free from any form of professional self-interest and bias.

Another doctor practising autogenic training also employs rhetorics of patient safety and danger when she describes her motivations for introducing the therapy to her NHS patients:

the reason I run the autogenic classes for my patients is because I couldn't hand on heart knowing how well some of the therapies that I use work give them a tablet because a drug company said this is licensed for such and such. I mean it's a kind of wacky perception I suppose and I say wacky because it is wacky in that if you're trying to straighten peoples' minds out to give them something that perhaps scrambles their brain a bit more, as they put it illogical and the other thing is it gives the patient no control. I think there are uses for traditional medicine I think there are also times you should say wait a minute is there something else that works better here and *it may well be that they work in tandem* but I think that you have to keep an open mind about it and I'm not, traditional medicine's my main background but I now feel I'm a better doctor and *I can do patients less harm because I've got other stuff*.<sup>115</sup>

In this talk above Dr 14 not only construes autogenic training as providing a potentially less harmful approach but also in doing so presents a combined role for the therapy and more conventional treatments - it may well be that they work in tandem.

As the next section explains the notion of combined practice - the mixing and blending of complementary and conventional treatments to deal with the same patient or particular medical problem - is commonplace within the GPs' accounts and is often described in close connection with the issues of safety outlined above.

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<sup>113</sup> Dr 6.

<sup>114</sup> Dr 11.

## 5.7 Combined Practice

As chapter four shows many of the GPs are keen to demarcate their practice of unconventional therapies as ‘complementary’ in contrast to the ‘alternative’ style of treatment which they see as being offered by lay practitioners. A primary component of this boundary-construction relates to the way in which the GPs highlight the supplementary and adjunct role of complementary therapies (they should be used only after conventional diagnosis). As sections four and five of the present chapter have illustrated this boundary construction is further supported by the GPs’ constructions of clinical reality, where they talk of complementary medicines filling gaps and of using the therapies in a restrictive manner (only dealing with a small range of often quick, simple problems that in many cases orthodox medicine has failed to relieve). In this sense many of the GPs explain their approach to unconventional therapy as being pragmatic rather than pure or academic (as chapter three illustrates these discursive constructions help to deauthenticate lay therapy). The present section of the analysis focuses more directly upon one topic identified in the GPs’ accounts which helps further enhance such a presentation: what is here termed combined practice.

Talk of iatrogenic illness and side-effects of conventional treatments (as outlined in section 6 of this chapter) is also predominant in the GPs’ descriptions of combined therapy and can be seen to help justify this style of practice. The doctors express concern about conventional drug-based interventions which may lead to side-effects. Here the doctors present complementary therapies as helping improve the safety of patients while they are still taking conventional drugs through combined prescriptions. As Dr 24 puts it:

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<sup>115</sup> Dr 14. Here we can identify the link between safety and a presentation of a combined use. Also there is an outline of a firm ‘adjunct’ use (filling gaps).

there's no doubt that many patients I've treated have reduced the number of pain killers they are having to take through the acupuncture. That's one of the ways we gauge whether it's helping or not because what you can say to them is well how much of your coproxamol have you used and they say well I'm down to two tablets a day and these are sometimes people who are taking eight before.<sup>116</sup>

This GP above justifies combined practice and the resulting decrease in conventional drug prescription as a means of assessing the effectiveness of complementary medicine.

In relation to homeopathy both Dr 13 and Dr 6 suggest a combined role for their therapy in the respective quotes below:

sometimes you've to be careful with drug interactions and you know adding in something homeopathic can be grand because you're not then so worried about what they're already on I don't think there's any reason why you shouldn't.<sup>117</sup>

usually patients are on allopathic medicines anyway. I wouldn't tell them to stop them. I would start them on the homeopathic remedy and then I would say we'll see how you do now. For example if it's someone that had eczema started to get better they would stop using the creams anyway, they would use them less and less because they didn't need to use them, so they would gradually reduce their own dosage.<sup>118</sup>

And as another doctor practising homeopathy explains his integration of the therapy into his surgery:

I must say I don't give homeopathy where if a child in with a fever and a sore throat that looked septic, I wouldn't say here's some belladonna you know I'd say here are some antibiotics erm, so I'm, I would maybe use it with standard orthodox medicine but I would not use it instead of where there was a well recognised treatment for orthodox treatment, I wouldn't substitute it.<sup>119</sup>

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<sup>116</sup> Dr 24. Dr 21 also outlines a combined practice of homeopathy and conventional drugs. The doctor says: 'I do give homeopathic remedies alongside other things. Well not for the same condition because you obviously would lose, you wouldn't find out which worked but certainly when people are on other medication I'm quite happy to give them homeopathic remedies as well'. Dr 21.

<sup>117</sup> Dr 13.

<sup>118</sup> Dr 6. Dr 16 also talks of his combined practice in similar terms: 'helping people initially with some beta-blockers or something for something although you would then wean them off them with using homeopathy'. Dr 16.

<sup>119</sup> Dr 7.

And in her description of combined use Dr 14 states:

I would not exclude, they are not mutually exclusive to me and that's what I'm saying to you I find it very difficult to separate them out because they're skills that I would access as I felt appropriate for the patient and I might access the whole lot so I don't actually say well this is definitely a homeopathy situation or this is definitely a traditional medicine situation. I mean I would maybe see this as a situation that requires a traditional medicine input I may well also use a homeopathic remedy and I may also well advise autogenics if I felt there was a problem there or if hypnosis was gonna be useful then I would use that as well so I would tend to overlap rather than, I'll say to people would you like a homeopathic remedy because I think one might be useful here even though I'm giving you all these other things.<sup>120</sup>

These last two quotes illustrate how this talk of combined practice fits comfortably alongside the distinction between complementary and alternative style therapy expressed elsewhere in the accounts; to combine different medical and therapeutic techniques is portrayed as fundamental to meeting the requirement of each consultation as it unfolds.

Dr 23 outlines how he sees acupuncture as a possible means of curtailing certain side-effects sometimes associated with conventional medication. Again this illustrates the close relationship often found within the accounts between the repertoire of combined practice and that of safety and comfort for the patient. He says:

I sort of give them acupuncture and try and stop the medication a bit. People who have been on anti-inflammatories for instance who maybe have trouble with their stomach but the anti-inflammatories are the only thing that have helped, ordinary painkillers have not worked and they're starting to get stomach upsets because of their tablets and then I might think well if I give them a course of acupuncture if I can give them prolonged relief then hopefully they can stop their anti-inflammatories.<sup>121</sup>

This quote once again illustrates the construction of a supplementary role for the acupuncture in relation to combining the medicines; even though the complementary treatment may eventually be given in place of the original drugs prescribed,

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<sup>120</sup> Dr 7.



acupuncture is provided not as a first line of treatment but as a means of containing and reducing some 'unwanted' effects of conventional medicine.

Dr 20 similarly suggests his homeopathic remedies may be combined alongside conventional drugs and he too draws upon the rhetoric of safety and reducing a dangerous intake of drugs or eradicating side-effects as a means of justifying such integrated usage. He says:

hopefully what you can do is lessen their joint symptoms and their pain and their stiffness and obviously these people are on lots of anti-inflammatory drugs, maybe on steroids as well and what you, what I do aim to do is get the homeopathy in and see if I could lower the amount of other drugs that they're taking. Because you always worry about the side-effects of the drugs and the side-effects are common. So you're trying to introduce the homeopathy alongside the other treatments and if things improve then lets reduce the other treatment down and balance it out. So you may not at the end of the day, they may still be on conventional drugs but that doesn't, but they may be on smaller doses and using homeopathy alongside it.<sup>122</sup>

Dr 14 also illustrates how autogenic training is helpful in reducing dependency upon conventional medication:

I've got one lady who during the autogenic course, cause I'm always thinking if they're on medicines or something it might alter them, one lady who reduced her insulin requirement and she'd been on the same insulin requirement because she's very careful about her diabetes that she'd been on it for I think four or five years with no variation until she started autogenics and she's now continued to reduce her insulin requirement and you know you could say well that's just coincidental I don't think it is neither does she because she was so meticulous about her diabetes that she could not explain it in any other way. I mean she hadn't put on weight, she hadn't changed her diet, she hadn't changed what she was doing, but the relaxation that she got from autogenics.<sup>123</sup>

There is also another way in which combining the two types of medicine is presented by some GPs as a means of making conventional treatment more tolerable for the patient. In addition to lowering conventional drug intake some GPs also talk of

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<sup>121</sup> Dr 23.

<sup>122</sup> Dr 20.



complementary therapies giving control back to the patient. In the following extract of talk the GP explains how hypnosis can be used to provide more control for the patient (in this case a patient facing surgery for bowel cancer) helping prepare them for further medical intervention to come:

obviously if somebody has got a bowel cancer I would use traditional therapy obviously but I might also use some other therapy with them as well because that would be appropriate and it would make them at least have some understanding about how they can help themselves although getting the bowel cancer cut out is outwith their control but I might take them through their operation or something like that and get them to see themselves better, doesn't always work like that but I mean I've done some hypnosis with people going in for operations and they seem to be doing better.<sup>124</sup>

As we see from this last quote complementary therapies are portrayed as encouraging self-realisation and a certain degree of self-help. As this doctor describes the role of hypnosis, it helps certain patients understand how they can help themselves and helps them to see themselves better.

Another device employed by some GPs in relation to combined use is cost saving. One GP practising acupuncture appeals to the potential cost savings of decreased dependence upon conventional drugs:

If I treat somebody with acupuncture then I would hope that they would use less drugs and possibly be less in, be less in need of physiotherapy both of those things would come off my budget, my fundholding budget and it's possible that running an acupuncture clinic will therefore reduce my, my need to draw on that fund.<sup>125</sup>

Again, as with some GPs' suggestion that complementary therapies can save time in the long run, this particular argument may prove attractive to those involved in the costing and management of primary care - whether they be non-clinical staff or fundholding partners or other colleagues.

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<sup>123</sup> Dr 14.

<sup>124</sup> Dr 14.

As seen in the quotes presented in this section so far many GPs highlight the limitations of conventional treatments to justify combined practice. However, some GPs present combined practice as a response to another contrasting concern; the gaps in treatment which are experienced with complementary therapy. For example one doctor explains why he sees the combination of acupuncture and a more traditional treatment such as prescribing painkillers as an essential approach for tackling the problems of some patients:

I use combined use a lot because the acupuncture. I mean especially if they're starting a course after the first treatment they won't get much benefit anyway. They might get a bit of easing off of their pain for a day or two but they will invariably come back before they come back for their second treatment and so you have to give them medication to cover them. With the second treatment again you don't know how well they're going to respond so they still need something to cover them for pain and they are told to take it if the pain is bad and when they come back for a third treatment you can have an idea they can say well I've not had to take any of these tablets then you know you don't need to give any more prescriptions but I like to have the combination of the two because I don't feel, I feel the gap between each treatment is too long to let them go without painkillers.<sup>126</sup>

This presentation, like many others analysed in this chapter, helps the GP justify a piecemeal incorporation of unconventional therapy into the general practice setting.

As such, this talk acts to further bolster the boundary work discussed in chapter four - talk of the limitations of unconventional treatments fits alongside the GPs' insistence that the therapies are specialisms which require contextualisation and co-ordination by generalists in order to produce good complementary practice.

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<sup>125</sup> Dr 19.

## 5.8 Complementary Therapy as a Strategy to Relieve Boredom

I think you must never get complacent and you must keep pushing on and you must learn and be interested in what else is going on and other people's point. The GPs that I know that enjoy their work most do something a little extra. You know they all have a little something that they do to take their, to take them a little bit and not getting slugged under the onslaught of diarrhoea and sore throats. Acupuncture, hypnotherapy, homeopathy, they can fit that role. There are still a few of us who enjoy our work you don't hear much about them.<sup>127</sup>

[I]t's a chance to learn something different, a chance to learn something new...It's important in general practice if you're stuck with all the day-to-day work that you still feel as if you are learning new things. It's very invigorating if you can do that.<sup>128</sup>

[Y]ou get fed up with the same old routine stuff, but you know I do think it's important that you do develop other skills in general practice

Interviewer: why is that?

I think you can get into a rut 'cos a lot of the time you're seeing, you come across things that really don't tax you very much 'cos you know you get into a routine. Joking we say if a patient comes in you have to shake yourself and say wait a minute is the brain working.<sup>129</sup>

Another rhetorical theme which can be identified from many of the GPs' accounts relates to the 'boredom' and 'routine' nature of general practice. Some of the doctors stress how the job can be dull and monotonous and how these features can lead to 'burn out' and 'ineffective doctoring'.<sup>130</sup> Practising complementary therapies is presented as a means of combating this boredom. The therapies are portrayed as challenging for the doctor and the difference of the unconventional consultation (qualitative feel and nature) from that of the normal GP consultation is highlighted as a 'change of pace'. In this sense, the therapies are presented as one valuable tool for

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<sup>126</sup> Dr 23.

<sup>127</sup> Dr 24.

<sup>128</sup> Dr 4.

<sup>129</sup> Dr 7.

<sup>130</sup> Dr 12. Indeed job satisfaction amongst GPs and its relationship to effective doctoring has attracted attention from sociologists. See Melvin, A. (1980). 'Job Satisfaction in General Practice: Implications for Prescribing'. *Social Science and Medicine* 14a: 495-499. Bridgestock, M. (1978). 'Assessing the

maintaining effective general practice. Again, these claims are helpful in the GPs' debates and negotiations with colleagues and others in that they act to further legitimate integrative practice within the doctor's surgery.

In relation to this area of their talk as with others we can once again identify how the GPs often present imagery of general practice as a pragmatic and flexible branch of medicine.<sup>131</sup> For example Dr 10 talks of the opportunities of general practice and how these are associated with the integration of complementary therapies:

in general practice you have a great opportunity not to be bored but nevertheless it can be appallingly boring right even though there is a constant difference after a while you realise that although it's different every patient's different that walks in and it's different every day and it's different every week if you take six weeks it's exactly the same as the last so it's nevertheless a repetitiveness about it, so if you've got complementary, you need to find ways of keeping yourself stimulated and interested, the complementary therapies are good for that, that's one thing that makes general practice an ideal place for it.<sup>132</sup>

And Dr 9 uses comparable language when he describes what he sees as the link between developing the practice of complementary therapies and enhancing job satisfaction:

I think that undoubtedly job satisfaction has got a lot to do with it and I think you, you know, I see general practice as an opportunity to, to expand and widen one's interests, hmm, within medicine certainly, ahm, it's, there's every opportunity to do that if you want to take it and I'm sure that that does prevent morale sliding.<sup>133</sup>

Section four of this chapter demonstrates how some of the GPs present complementary medicines as introducing a technical fix for conditions which remain untreatable with only the aid of conventional medicines. Moreover, connected to this

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General Practitioner's Job Satisfaction Today'. *General Practitioner* 38: ?-?. Mechanic, D. (1974). *Politics, Medicine and Social Science*. New York, Wiley-Interscience.

<sup>131</sup> This imagery plays an important role in the boundary-work concerning lay therapists and as will be seen in chapter six it is also a device employed in the attack of hospital medicine.

<sup>132</sup> Dr 10.

claim a few of the doctors draw upon the classification of the heart-sink patient. This classification is also exercised by some GPs with regard to the theme of job satisfaction. The use of this classification can be identified in the lengthy stretch of talk below where Dr 17 describes how hypnotherapy can help guard against boredom:

I've been doing this same job now for thirty years or so, twenty years ago it was quite good to say let's look at it with new eyes, you do get bored you do get fed up, there is a sameness to it although there's always things that are different you know there is well I certainly was getting fed up and I think this helps it's stimulated the interest again a bit.

Interviewer: how's that?

I was looking at things differently. Well instead first with the hypnosis instead of being fed up and bored stiff by patient X coming back in and telling me how uptight they were and how fed up they were you know how they couldn't sleep and all these things I had something to offer them and I could say I wonder if I teach them self-relaxation if it would make any difference or instead of them being a heart-sink patient because I couldn't treat their conditions they became somebody that maybe I could experiment on, let's have a try here, let's see and so there was this stimulated you to think about things that maybe you'd given up thinking about because you'd tried everything...so if you ask any general practitioner they'll have heart-sink patients and the heart-sink patients are the ones they can't do anything for but who keep presenting and that's quite nice to have something to offer them so it makes you feel better.<sup>134</sup>

As we can see from this quote the doctor suggests that with the use of hypnosis those patients previously considered heart-sink patients - patients who are perceived as a classic example of the frustrating and boring case - are now redefined as exciting and challenging cases. Another GP, talking about complementary therapies more generally, employs congruent terms:

I think with general practice it can be a very mundane job if you have a succession of trivial conditions, self-limiting conditions coming in a lot of social problems you can't do an awful lot about. You think well what's the point really to do this job, when you get something, either someone with some dreadful condition that you actually manage to help whether by acupuncture or some other means I think you do get satisfaction out of it and if there's

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<sup>133</sup> Dr 9.

<sup>134</sup> Dr 17.

something a wee bit extra that you can provide that perhaps some other people can't provide I think it gives you that little edge and maybe quite pleased with yourself at times but I think that it does help your self-esteem if you feel that you have a little bit of experience in an unusual field.<sup>135</sup>

Dr 10 likewise explains how she perceives the practice of complementary therapies as a means of providing the GP with personal satisfaction. The following extract of talk illustrates how the personal satisfaction gained from complementary practice is sometimes explicitly presented by these GPs to justify the integration of complementary medicines within general practice. She says:

I really think in general practice now its becoming so awful in many ways and so over burdened with bureaucracy and it's like taxation without representation, there's an awful feeling in general practice just now that you really do need something that gives you a bit of personal satisfaction and I think paying good, its something that's a little bit special as the complementary therapies are, is a good feeling, and that's another reason for it being in general practice.<sup>136</sup>

A major theme located in the GPs' talk which is often found alongside talk of job satisfaction is that of the GP's own state of well-being. Complementary therapies are projected by some GPs as healing the doctor in addition to, and often as a means

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<sup>135</sup> Dr 23. Similarly Dr 24 talks of keeping ahead of change when he talks of making general practice interesting and how he sees complementary therapies as encouraging that. He says: 'I think there are areas erm of care where you can do a little bit more and make it interesting. I'm very conscious you've got to make general practice interesting and keep it going otherwise you become sludged under.

Interviewer: Can you expand that for me?

Well I think by the time you go through a medical training your brain's pretty dead. I mean everybody knows that, it's a sort of continuous drive and then you do three years usually of hospital medicine and a year as a trainee which I very much enjoyed but and then you come out into practice and you arrive day one nine o'clock in the morning and there are twenty patients all ready to, and that's how it goes and you spend your entire life seeing thirty forty people a day and your brain is very much, you're surviving, you're trying to survive all the time instead of fighting and making it interesting because it is actually quite a fascinating and you've got to make it interesting though it'll not come on its own. You can sit here and you can write prescriptions all day or you can fight and you can make it enjoyable. You keep up with change, you try and lead change and not be sitting behind everybody else. That's when people become demoralised I think when they're being dragged along. Someone once said the nice diagnosis of depression is when you lose control and you are no longer in control of events of your life and everything affecting you so you try and get in there and be ahead of it and pushing for change and in this practice we are fortunate that we are one of the practices that's pushing forward on things'.

<sup>136</sup> Dr 10.



of, restoring a healthy state for the patient. Dr 16 below utilises this form of rhetoric and more specifically describes his hypnotherapy as a way of dealing with the stress he himself suffers as a result of lack of time and other constraints. He states:

you're working to time constraints and all sorts of other constraints and I mean if you allowed it you'd have yourself all screwed up and that rubs off on everybody and hypnotherapy helps with that. I think even while you learn to do it it allows you to tap into resources that allow you to relax more. You only need to do a hypnotherapy training weekend and you're absolutely so laid back you're nearly off your chair.<sup>137</sup>

Connected to this style of talk Dr 11 describes general practice in terms of 'pressures' which lead to both cynicism and 'burn-out'. He explains:

the situations and the pressures are such that as time goes on they get a bit more cynical and a bit more run down and a bit more burn-out such that they maybe started off in general practice being enthusiastic, holistic, caring, et cetera, et cetera, and then it goes because they're human and the pressures are immense. Complementary medicine gives you another, it gives you another dimension. I think part of the burn-out is people getting a bit cynical, bored, tired, cynical. I think cynicism becomes a part of burn-out and I suppose it's a nice different skill, another attribute.<sup>138</sup>

Also embedded in this last quote is the suggestion that pressures and burn-out may lead to doctors who over time become less caring, enthusiastic or holistic in their approach to patients. Another GP evokes related imagery when he talks of the routine of general practice and how complementary therapies can inject a new interest in the job:

I think in general practice you can get very much into this routine of just you know well you know patient after patient see them, do it, get away with them, that kind of pattern and you know I've got a lot of years left before I can retire and I would like to think that I can keep my interest up for all that time and it's nice just to now have something different to do.<sup>139</sup>

The talk examined in this section demonstrates how many of the GPs depict either their particular complementary therapy or complementary medicines

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<sup>137</sup> Dr 16.

<sup>138</sup> Dr 11.

<sup>139</sup> Dr 22.



more generally as a defence against stress resulting from pressures such as time and also more commonly against boredom resulting from the routine and mundane aspects of general medical practice.

## 5.9 Summary and Discussion

As can be seen from the quotes presented in this chapter the GPs interviewed for this study employ a whole range of different rhetorical devices as a means of legitimating complementary therapies to the clinical setting of general practice. These include: an appeal to the safety of unconventional medicine in contrast to the potential dangers of conventional techniques; highlighting unconventional therapies as a different pace and style of practice which helps fight against complacency and maintain morale; presenting their complementary therapy as having a restricted application, to be used essentially as a complement to or filling gaps in existing techniques.

It is important to note how some of these claims contrast with certain presentations offered elsewhere in the GPs' accounts. In particular, as we have seen in the present chapter, GPs seek to authenticate the use of unconventional therapies within general practice by describing them as inherently safe, natural and side-effect free. In contrast, if we turn back to the analysis of boundary construction in chapter four we see that the GPs present unconventional medicines as potentially dangerous in the hands of lay therapists. Here we have evidence of the flexible employment of interpretative frameworks whereby different, often contrasting, rhetorics are used to describe the same object of talk in order to accomplish different ideological tasks. Such flexibility is an important tool with which these GPs maintain and enhance their professional status and dominance in the medical arena.

We can see how the arguments and claims presented in this chapter act as potentially forceful and persuasive devices in the internal debates within general practice about the authenticity and worth of integrative complementary therapy. Unconventional medicines are still practised predominantly outwith the boundaries of

the orthodox medical community, and still tend to be regarded as distinct from those conventional treatments which are routinely offered on the National Health Service. Furthermore, for all the signs of incorporation in recent years, the actual number of GPs practising unconventional techniques is still relatively small,<sup>140</sup> and the therapies still remain a controversial topic within the ranks of general practice.<sup>141</sup> Given these circumstances we can contextualise the attempts of these GPs to integrate complementary medicines into their practice in terms of the concepts of social world theory and related perspectives. Such practitioners would appear to be faced with an overriding need to convince others within their particular medical community of the worth and legitimacy of integrative practice. What we have here is an example of authentication processes whereby members of this medical world attempt to translate particular medical knowledge, technologies and practices - which have been until now generally considered by individuals of their world as the concern of other medical worlds - and make them palatable to others in *their own* world. As illustrated in this chapter there are a number of rhetorical devices with which the GPs justify their practice of complementary medicines, and these can be interpreted as attempts to counteract some of the criticism of and opposition to integration from others within their immediate medical world.

Furthermore, linked to appropriation processes are also issues of 'constraint'.

While outlining a number of constraints (e.g. cost constraints and constraints from

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<sup>140</sup> As Sharma rightly points out, 'Whether patients can obtain non-orthodox treatment from a general practitioner under the NHS depends entirely on whether they happen to be registered with one of those few GPs who not only know something about non-orthodox but who actually offer it to patients on a regular basis. Otherwise the most that can be hoped for is advice about non-orthodox treatment or (possibly) a referral to a local practitioner who is known to the GP'. Sharma, U. (1992). *Complementary Medicine Today: Practitioners and Patients*. London, Routledge. p.94.

<sup>141</sup> See Ernst, E. (1993). 'From Alternative to Complementary: Changing the View from the Fringe'. *British Journal of Hospital Medicine* 50: 81-86. Visser, J. (1991). 'Communication between General Practitioners and Alternative Practitioners'. *Complementary Medical Research* 5(3): 172-177. Editorial (1994). 'Fraternalizing with Fringe Medicine'. *British Journal of General Practice* 94: 243-244.

practice partners) I have argued that these all in some way relate to the themes of time and efficiency. As illustrated, the pressure of time plays a dominating role in many areas of the GPs' narratives. While this pressure may initially seem to imply the 'unsuitability' of general practice as an environment for complementary medical practice, closer analysis reveals that many of the doctors overcome this 'tension' in their accounts through a number of specific presentations. These include such things as: making appeals to the use of 'quick style' treatments and limiting the scope of their complementary skills; and the claim that immediate time investment will lead to improved long term time management and cost saving.

What remains to be seen is the extent to which such 'quick' GP style therapy will prove acceptable within both healthcare and wider public debate. Furthermore, it must be noted that even from within the complementary medical community some have questioned the desirability or effectiveness of 'brief' style complementary consultations within general practice.<sup>142</sup>

Another interesting feature of the talk examined in this chapter is how it acts to support and strengthen some of the GPs' claims and presentations highlighted in chapter four. In particular, the lay practitioner/GP divide - built primarily upon a distinction between complementary and alternative styles of practice - is further enhanced by the GPs' portrayal of their own clinical reality. To claim worth for such features as restricted scope and combined use of the therapies is to claim legitimacy for a piecemeal and supplementary style of integration in line with the complementary role advocated in the boundary work of chapter four. Obviously, these claims also

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<sup>142</sup> As Peters asks is 'brief intervention - TCM, - massage, - homeopathy or - osteopathy, perhaps based on a thirty - or even twenty-minute "NHS unit", practical or desirable?...time and touch are important elements, so could a [complementary] consultation be shorter without fundamental detriment', Peters, D. (1994). 'Sharing Responsibility for Patient Care'. In S. Budd and U. Sharma (eds). *Op. Cit. No. 15*. p.185.

help in the presentation of complementary therapies as specialisms in as much as the medicines are seen as necessarily dependent upon the solid foundation of a conventional medical approach. Here the focus is predominantly upon unconventional medicines as an 'add-on' and 'additional' avenue of treatment, filling gaps left behind due to either the ineffectiveness of conventional therapy for particular conditions or its unsuitability for particular patients or medical problems.

This last point also emphasises another significant feature of the GPs' talk. It draws our attention to how these doctors draw upon a range of problems associated with modern conventional medicine (generally the limits of conventional medical science and techniques in the form of either iatrogenic illness or an inability to deal with particular conditions) for their own ideological purposes. Curiously, such talk of the limitations and problems of modern conventional medicine, which originated as a means of attacking contemporary medical practice, is here seen to be used by this branch of the medical community as a means of contributing to the processes of appropriation and translation whereby complementary therapies are authenticated within the medical setting of general practice.

The limitations of modern conventional medicine are also linked to the attempts by these GPs to accomplish other ideological tasks. As will be seen in the following chapter this is particularly evident in the GPs' boundary-demarcations from hospital medicine; the alleged 'problematic' characteristics of modern high technological medicine identified by many critics are firmly associated in the GPs' accounts with the hospital setting and as a result these 'failings' are distanced from good general practice. These and related themes which are used to create the boundary between the hospital and general practice are the topic of chapter six.

## **Chapter Six**

**Images of Professional Identity, Integrative Medical Practice and the Hospital/GP**

**Divide**

## 6.1 Introduction

This chapter explores the boundary-construction found within the GPs' accounts which relates to general practice/hospital medicine. The analysis centres upon the theme of professional identity and a number of related issues identified in the GPs' talk.<sup>1</sup> As a means of introducing the theme of professional identity as found within the accounts it is useful to refer to one short extract from one of the interviews. This GP acupuncturist is discussing alternative therapists outside the medical profession and what he sees as their dogmatic employment of an alternative medical model.<sup>2</sup> But, more importantly for the discussion here, what can also be identified from this extract of talk is his reference to the identity of a GP. He states:

a lay acupuncturist would be very defensive of their own territory. They don't want other people encroaching on that, therefore they want to hold on to the theory of it and how it works whereas *I know where I am, I'm a GP and I have my own way of working.*<sup>3</sup>

While not actually defining the identity of a GP, the doctor above quite explicitly appeals to his identity as a general practitioner as a means of distancing his practice from that of others - in this case from lay therapists. Indeed, across all of the accounts there is an appeal to the identity of general practice as a discursive tool for explaining and justifying a whole range of different issues and also as a means of constructing a number of different areas of boundary-work.

Studies have claimed a diversity and variation within general medical practice, both in terms of tasks undertaken<sup>4</sup> and work styles.<sup>5</sup> As one writer suggests, 'general

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<sup>1</sup> It must be noted that the theme of identity is not divorced from the other three analysis chapters. Indeed, any discussion of boundaries and territory implicitly introduces the concept of identity. However, this chapter deals directly with one particular area of identity construction found in the accounts.

<sup>2</sup> An issue already explored more fully in chapter five.

<sup>3</sup> Dr 4.

<sup>4</sup> Calnan, M. (1988a). 'Variations in the Range of Services Provided by General Practitioners'. *Family Practice* 5(2): 94-104.



practice is a profession characterised by idiosyncrasy and thus by a great degree of variability in both standards and approach'.<sup>6</sup> General practice, like all professional communities or worlds, is not to be seen as a homogenous or a predefined set of practices or ideas. Instead, as social worlds theory suggests, it is a site of constant negotiation and debate over authenticity and worth. Given these circumstances, what may appear at first glance as a somewhat routine and preordained line of inquiry into how the GPs in the study present their professional identity and role is, on closer inspection, to be considered a more problematic and complex issue.

So how do these GPs construct their professional identity and where do they locate themselves in terms of medical role and responsibilities within their accounts? Here all the GPs appear to draw heavily upon a number of related and interwoven rhetorical devices. These devices include appeals to the artistic, idiosyncratic and intuitive nature of general practice, the centrality of relationships to the work of the GP, visions of the GP as the doctor of and in the community and descriptions of general practice as a holistic form of medical practice. In this chapter I expose the ways in which the GPs' presentations of their complementary therapies are tied to these descriptions of professional identity. The analysis shows how the development of unconventional therapies is justified with reference to these rhetorics and in turn how the therapies are employed by my GPs as a means of appealing to, and further legitimating, certain images of professional identity.

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<sup>5</sup> Bucks, R. S., Williams, A., Whitfield, M. J. and Routh, D. A. (1990). 'Towards a Typology of General Practitioners' Attitudes to General Practice'. *Social Science and Medicine* 30(5): 537-547. Calnan, M. (1988b). 'Images of General Practice: The Perceptions of the Doctor'. *Social Science and Medicine* 27(6): 579-586. Jefferys, M. and Sachs, H. (1983). *Rethinking General Practice*. London, Tavistock. Horobin, G. and McIntosh, J. (1977). 'Responsibility in General Practice'. In M. Stacey, M. Reid, C. Heath and R. Dingwall (eds). *Health and the Division of Labour*. London, Croom Helm. Mechanic, D. (1970). 'Practice Orientations Among General Practitioners in England and Wales'. *Medical Care* 8: 15-25.

<sup>6</sup> Bucks, R. S., Williams, A., Whitfield, M. J. and Routh, D. A. (1990). *Op. Cit. No. 5*. p.537.

The GPs' broader descriptions of general practice are also identified as a part of intraprofessional boundary-work. The analysis reveals the ways in which the GPs' descriptions of and justifications for integrative medical practice can be seen as a contemporary strategy with which to further demarcate and distance general practice from hospital medicine and specialists. I argue that unconventional therapies provide these GPs with further resources with which to claim a medical role distinct from hospital medicine and thereby help the GPs in their ongoing struggle over role and identity within the wider medical community.

## 6.2 Intuition, Idiosyncrasy and Artistic Practice

I'd always felt I was more of an intuitive doctor than an academic doctor.<sup>7</sup>

Many of the GPs employ what shall be here labelled the rhetoric of 'intuition' in their descriptions of general practice. Some define themselves as 'intuitive doctors', others refer to the intuitive nature of general practice and how they often follow 'gut reactions' in clinical practice. In this sense, the GPs present their practice as based, to a large extent, upon tacit knowledge.<sup>8</sup> Dr 5 provides an extensive outline of intuition and how she perceives it to be a core feature of the clinical practice of all GPs. She states:

doctors don't have a concept of the knowledge they have because they've had training over such a long time and so much they've just picked up by osmosis and also it's got to the stage, you know, the sort of four blocks, you know, the one where you don't know you don't know, the one where you know that you don't know, the one where you move into knowing you know and the one where you move into not knowing you know and it becomes unconscious and so much what doctors do have got to that fourth box and they are totally unaware, even look at a person and it may say you look very bloodless, you look very anaemic to me and they need to be checked out and it's this, where does it come from? it's unconscious, it's taking in information and processing it at this unconscious level through the experience you've picked up over the years. You've got something that is just there picking it out, picking it out and it triggers the knowledge even from the past and it's in the vastness of the knowledge that doctors in general practice have is often forgotten by them because so much of it has moved into that not knowing they know. It's there, it's stored away there and when they need it it comes out.<sup>9</sup>

Apart from employing intuition in their general descriptions of practice, the repertoire of intuition also plays an important part in many of the GPs' descriptions and understandings of their complementary therapy(ies). A clear example of this rhetoric can be found in the following extract from the interview with Dr 3 practising

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<sup>7</sup> Dr 6.

<sup>8</sup> For discussion of this concept see Wainwright, H. (1994). *Arguments For a New Left. Answering the Free Market Right*. Oxford, Blackwell.

<sup>9</sup> Dr 5.

homeopathy and hypnotherapy. She says, 'If you have no intuition as to where people are or the effect of what you're saying on people you'll never be able to do complementary medicine'.<sup>10</sup> And as she later adds, 'I think you have to have intuition to be able to do well at complementary medicine and you, but it's something that becomes very highly developed if you have it and you're doing complementary therapies'.<sup>11</sup> The following quote illustrates quite clearly how one GP homeopath links her practice of homeopathy to the discourse of intuition:

I'd always felt I was more a sort of intuitive doctor than an academic doctor, but there was still something not there in general practice. So I started the homeopathy because you're actually looking at patterns, its a different way of looking. You're not looking at it in a linear fashion, you're looking on it in a sort of pattern recognition fashion, its a different way of looking at it'.<sup>12</sup>

In line with this extract of talk many of the GPs employ the discourse of intuition to provide a sharp contrast between their medical practice and what they perceived as a strict scientific medical model. In these cases, the GP homeopaths and hypnotherapists appeal to the conceptualisation of personality types - drawn from their complementary therapies - as a means of justifying the development of these treatments within general practice. As one GP homeopath explains in the case of homeopathy:

homeopathy isn't something, you can't be half-hearted about it because it's a big, as I've already explained, it's difficult to believe it can work, and, you know, it really depends on, maybe it depends on which sort of *left or right person*, I don't know but there are some people who just find it very difficult to do and that's fine.<sup>13</sup>

Many of the GPs describe complementary medicines as 'right-brain' therapies requiring an intuitive style of thought and personality on the part of the practitioner.

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<sup>10</sup> Dr 3.

<sup>11</sup> *Ibid.*

<sup>12</sup> Dr 5

<sup>13</sup> *Ibid.*

They claim that right-brain processes are associated with the intuitive dimension of practice while left-brain thinking follows a scientific approach. In these cases (such as the extract above) homeopathy or hypnotherapy are no longer simply justified through an appeal to an intuitive discourse, but also, in turn, these GPs explain their intuition in terms of ‘personalities’ that they see as governing their complementary medical consultations. As the hypnotherapist quoted earlier explains elsewhere:

well, I think its very difficult to do complementary medicine well without (intuition) and I think that a lot of people who are doing it well need to be from that group of people. Just as your scientist, a scientist with intuition is useless, the scientist needs to be able to really look at hard facts, do...you know, are they right? you don’t want a scientist and the person who’s intuitive will jump from stage one to stage six and be unable to explain how they got there and they may be wrong, there will be times when you are wrong, the scientist will go one, two, three, four, five, six.<sup>14</sup>

Alongside their talk of intuition some of the GPs also present images of idiosyncratic practice. Illness itself is conceptualised as idiosyncratic (i.e. different in different individuals) and, consequently, the idea of fitting patients and their treatments ‘into boxes’ is presented as deficient in the context of general practice. Complementary therapies, as described by the GPs, correspond to this ‘complex’ conception of illness, in that they encourage the practitioner to tailor treatments to the particular needs and personalities of individual patients. For example Dr 6 states:

when I started doing medicine I’d wanted to be a doctor since I was about nine and initially I was really interested in surgery. I was on the surgical bent. But then I didn’t think it, well, I didn’t do very well in surgery. I mean, I started off and I wasn’t good at sitting the exams because the one thing I’m bad at is multiple choice exams, *I think that’s part of why I’m good at homeopathy because it needs a certain mind you see*, erm, I couldn’t tie myself down to saying that’s always the case or it’s always number one every answer, putting things in boxes doesn’t work for me and I was always great at short essay questions and long questions and things like that. As soon as anyone ever stuck a multiple choice in I thought I can’t tie myself down to

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<sup>14</sup> Dr 12.

saying that is the answer because there's always the possibility that, you know, something doesn't fit.<sup>15</sup>

In this extract above we can see how the GP presents a close relationship between an idiosyncratic approach to practice and homeopathic medicine. She describes how her ability to successfully answer a particular style of examination questions - essay questions rather than multiple-choice tests - reflects and is linked to her interest in homeopathy and the 'style' of thinking this therapy requires. Dr 15 also talks of the idiosyncratic aspects of homeopathic consultations. Here the GP explains the sometimes unexpected and often unexplainable dimension of homeopathy in terms of 'flash stuff'. To quote the GP:

I suppose there's another aspect of homeopathy which I would allow and that is the kind of stuff that, the flash stuff that kind of just comes up before you, I have no idea why

Interviewer: Can you explain that for me?

Well like now. I'm chatting to you and you're talking to me as a patient and I suddenly think oh silver nitrate, I don't know why I thought silver nitrate and I can't analyse why I've thought it but I might then stop and think well that's come up just as you meeting me has come up. I don't take it that any consultation is purely chance. No, I think if things come up in consultations any sort of insightful things like that I would take that as being something to do with what happens between us and whatever that is whether I suddenly you know feel that I should talk to you about your father, now I don't know why.<sup>16</sup>

Interestingly, this description of 'flash stuff' also incorporates a vision of the consultation as possibly involving a wider exploration of the patient's life and circumstances. It also suggests that every consultation is important - it helps reconceptualise trivial medical cases, and, in these terms, this stretch of talk augments

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<sup>15</sup> Dr 6. This quote also illustrates how intuition can be a powerful discursive device which is employed to demarcate specialist medicine (in this case surgery) from general practice. This theme is more fully explored later in this chapter.

<sup>16</sup> Dr 15.

some of the themes which relate to boredom and job satisfaction explored in chapter four.

Dr 5 practising hypnotherapy also describes her approach to the therapy in terms of idiosyncrasy. She says:

you have this sort of communication with [the patient] at another level and you know what they're doing and it is extremely difficult to repeat what you've done after you've done it

Interviewer: It's a one-off kind of thing then?

And all this therapy should be, to be effective. You are, I will sometimes plan what I'm going to do and do something totally different. The only thing that I have used now on a very planned basis is stuttering because I've got something that tends to work with stuttering but with anything else I have no idea what I'm going to do when the patient arrives. Now, I spoke to one of the good clinical psychologists and he said you've got to know what you're doing so that you can repeat it and that is not how you get good work.<sup>17</sup>

This quote shows how talk of an idiosyncratic approach to practice is used by some of the GPs as a means of demarcating themselves from specialists in other fields. In this case the GP produces a distinct boundary-construction between her idiosyncratic style of practice and the more rigid and systematic approach of the clinical psychologist. As will be seen a little later in this chapter this and other related rhetorical devices are also used to demarcate general practice from the hospital environment and the practice of hospital doctors.

The rhetoric of intuition is augmented in many of the accounts by an appeal to the artistic nature of general practice. As Gordon suggests, the notion of art in medicine links with intuition in that both highlight clinical experience as opposed to, or in addition to, clinical science.<sup>18</sup> In the following quote Dr 1 describes the artistic

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<sup>17</sup> Dr 5.

<sup>18</sup> Gordon, D. (1988). 'Clinical Science and Clinical Expertise: Changing Boundaries Between Art and Science in Medicine'. In M. Lock and D. Gordon (eds). *Biomedicine Examined*. London, Kluwer Academic.



element of general practice as extending, yet ultimately being based upon, a scientific medical approach. He states:

you know medicine is an art which is based on science. I've no doubt that well certainly in general practice, general practice is mainly art but based on science because no matter how well trained you are it's based on you becoming better at it and more experienced you become, it depends on your skills, your interrelationship skills with people and the more effective you are at doing that the more effective you'll be as a GP.<sup>19</sup>

Likewise, having explained what she sees as the importance of scientific medical knowledge, Dr 3 then goes on to say:

the rest is art

Interviewer: Can you expand that?

OK, I'll tell you what the art is in general practice. We have a seven and a half minute appointment and that's quite lavish so Joe Soap comes in the door. I've maybe never seen him before and we have to establish a rapport. He has to tell me his innermost secrets...and I have within seven and a half minutes to listen to this and make up my mind which symptom is the problem, where I'm going to make a diagnosis, sometimes examine then write my notes up because if I'm sued and if I haven't got good notes I'm in the shit and decide on a therapeutic treatment or outcome, write a prescription, explain how to take it, tell him whether he's to come back, what the side-effects are, sometimes write a referral letter to a hospital coherently and that's the art, fitting that in or knowing how to short circuit things, or knowing which things you can short circuit which things you can side track or knowing which patients you have to say look come back I want to look at this more closely and that's the skill that's learned...that's the art, that's something that only experience and observation will give you the difference between somebody who is ill and somebody who is not ill.<sup>20</sup>

First, this talk identifies the art of medicine as an addition to a scientific medical grounding. Second, the notions of clinical experience and clinical observation are expressed (in this case directly) as necessary and pivotal elements to acquiring the skills and abilities of an authentically good general practitioner. More particularly, this GP links the art of general practice with the issue of time management; the art of

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<sup>19</sup> Dr 1.

practice is the ability to conduct satisfactory consultations within the confines of a seven and half minute slot - a claim which connects to some of the themes explored in the previous chapter.

Another GP explains his perceptions of the artistic side to general practice:

There's a colleague of mine not far from here who has an arts degree, who came from a family where, in the old days when GPs were rich his father was a GP and he said before you lads make any decisions about what you're going to do in life you must do an arts degree and he actually did fine art, he did the history of fine art and I've heard him speak on a number of occasions and there's also a fairly, or there's been one or two active meetings on the application of the arts and art to medicine. I think more and more people are coming round to, back to the view I think, that the application of medicine has a lot to do with arts and that painters, for example, have a lot to teach us about how people see bodies and how people view the world, a literal view, books too, full of fascinating things about medicine. Doctors in general probably don't read enough broadly but general practitioners, I know several very interesting general practitioners and it tends very often to be GPs, psychiatrists are the other group of people that are interested in that. You won't get a surgeon interested in all that!<sup>21</sup>

Here the GP acupuncturist produces a much more explicit boundary-demarcation between general practice and hospital medicine through a somewhat literal construction of an artistic discourse. It is suggested that while surgeons are not interested in the artistic side to medical practice, in contrast GPs are more likely to explore art and its relationship to their clinical work. Implied in this extract of talk is a notion of the general practitioner as a well-rounded and interesting individual. In contrast, through the suggestion that surgeons are not interested in the arts, these specialists are cast as inward thinkers closed to other experiences beyond the boundaries of scientific medicine.

Indeed the rhetorics of artistic, idiosyncratic and intuitive clinical practice are important interpretative frameworks not only employed to manufacture a particular

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<sup>20</sup> Dr 3.

<sup>21</sup> Dr 24.

identity but also to help demarcate between general practice and medicine practised in the hospital setting - a point which is explored in more detail later in this chapter.

### 6.3 General Practice, the Community and Social Relations

I think general practice is very much based upon relationships, relationships with patients.<sup>22</sup>

People come in and people, I've known their parents, their grandparents and already when they walk in the door I already have an attachment to them. I have a link, I don't have to say anything, I don't have to introduce myself.<sup>23</sup>

The notion of community has often been a popular rhetorical tool with which GPs have attempted to define their role and identity.<sup>24</sup> Furthermore, formal bodies representing the profession have also often identified or framed the GP as the 'community' or family doctor.<sup>25</sup> Within the GPs' accounts can be found similar imagery and rhetoric. As one GP acupuncturist describing his role as a GP says:

I've been here ten years now, ... I live in the community so I know the patients socially as well as professionally and I enjoy that. I enjoy that sort of involvement with people personally, professionally and socially and within the community as well.<sup>26</sup>

Similarly, Dr 20 explains how general practice encourages closeness and friendship with patients. The doctor says:

I think if you look at it the more you do in general practice, a lot of people I've got now are not patients they're friends really. You know over the years you get to know them quite well, you see them through life traumas, you share them together. It's more than just a, well it depends what you develop, I was going to say it's more than a doctor-patient relationship but it depends how

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<sup>22</sup> Dr 15.

<sup>23</sup> Dr 10.

<sup>24</sup> Horobin, G. and McIntosh, J. (1977). *Op. Cit. No. 5*. Riska, E. and Wegar, K. (1995) 'The Medical Profession in the Nordic Countries'. In T. Johnson, G. Larkin and M. Saks (eds) (1995). *Health Professions and the State in Europe*. London, Routledge. Indeed some sociologists have supported such presentations. For example Keheller, Gabe and Williams write of the development of the medical profession: 'Two strands developed. The general practitioner (GP), who was part of the same social world as the patient, often played a key civic role in his or her locality. The hospital consultant, meanwhile, was a rare breed to whom the familiar GP occasionally referred patients. He was a distant and recondite figure with access to knowledge which transcended local concerns and was unavailable to ordinary people'. Keheller, D., Gabe, J. and Williams, G. (1994). 'Understanding Medical Dominance in the Modern World'. In J. Gabe, D. Keheller and G. Williams (eds). *Challenging Medicine*. London, Routledge. pp.xi-xii.

<sup>25</sup> See Loudon, I. (1984). 'The Concept of the Family Doctor'. *Bulletin of the History of Medicine* 58(3): 347-362. Here Loudon examines the evolution of the concept of the family doctor in Britain.

<sup>26</sup> Dr 4.

you look at that, maybe that's a good doctor-patient relationship but it's gone from just a hard clinical approach to friendship.<sup>27</sup>

This quote also reveals how some of the doctors contrast their close involvement with patients to a 'hard clinical approach'. Also there is an emphasis upon the continual care offered in general practice as providing the right conditions for knowing patients well. These doctors suggest the role of the GP is situated at the very core of the local community, a central location, which they claim is facilitated by their unique continuity of medical care with their patients. Such rhetorical constructions appeal to the 'golden' days of medicine, a time before rapid specialisation and high-technological interventions,<sup>28</sup> and some of the GPs interviewed do describe their practice and style of doctoring with reference to similar imagery. They talk of a lost time but also claim that remnants of this disappearing age still guide general practice today. As one GP describes her perceptions of general practice:

there's also the continuity of getting to know people. I mean I've been here for what, fifteen years now and, you know, you do practise family medicine. Babies that were born are now teenagers and erm, the young women that were there when I started are now, have had their babies, this sort of thing, and that might sound *very olden and traditional* but there is satisfaction in knowing.<sup>29</sup>

This rhetoric of community and social relationships has two distinct strands. One strand links to the GP's claim to actual practice *in* the community; that is, in the case of house calls they see patients in their own environment outside their surgery. As one GP acupuncturist explains it it is a matter of 'being privileged to go and see

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<sup>27</sup> Dr 20. Dr 7 provides an other example of these rhetorical presentations when she says, 'I think that's part of general practice you get to know your patients well and the interesting thing is that you say oh yes you're so and so's daughter, you know you know the families as well'.

<sup>28</sup> For comparative discourse analysis along these lines, also relating to general practitioners (specifically female GPs in Nordic countries), see Riska, E. and Wegar, K. (1995). *Op. Cit. No. 24*. p.206.

<sup>29</sup> Dr 21.

them in their own homes as well and not just seeing them in the clinic setting'.<sup>30</sup>

Linked to this is also an insistence that being in the community (often over many years) provides an extensive knowledge and familiarity not just with individual patients but also with the wider family unit.<sup>31</sup> In line with many of the doctors, Dr 19 draws upon these rhetorics to describe his role as a GP.<sup>32</sup> He explains:

my role, I would say, is very much knowing as much as possible about somebody in all the different aspects of their health...getting to know people and finding, following them over a long period of time, finding out about them, getting to know their families, their kind of wider environment.<sup>33</sup>

The other strand of the community rhetorics relates not to the geographical location of the GP's medical practice but to the perceptions of patients. There is the suggestion that patients perceive their GP as being *part of* the community and that this entails a central location within the life of the community and of the individuals within it. One GP describes it in terms of 'being their GP rather than any other doctor that they might see',<sup>34</sup> and elsewhere in her account she expands on what she sees as her 'personal' style of doctoring:

It's, you know, it's having a list of patients that it's your responsibility to look after and your responsibility alone if you like, and that, you know, you're the bottom line and you have to deal with whatever problems there are, erm, you can't just shelve it on and you see people over years and you get to know them, you get to know their families, you are *their* doctor.<sup>35</sup>

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<sup>30</sup> Dr 23. Also Dr 12 explains his attraction to general practice when he states, 'you are closer to your patients, you live in their normal environment, you get to know their families'.

<sup>31</sup> For example Dr 10 employs these rhetorical tools to explain her general practice. She states: 'it's at a personal level at that, I know them and I know their family and I've been around for a long time and so they can feel comfortable with me or guilty with me or awkward with me but it's the knowledge it's not with you know hidden agendas'.

<sup>32</sup> This quote also exposes how the discourses of family and community doctoring are associated with the presentation of a holistic medical approach within the accounts. This issue is one which is explored in more detail later in this chapter.

<sup>33</sup> Dr 19.

<sup>34</sup> Dr 22.

<sup>35</sup> *Ibid.*

We can find similar rhetorics when Dr 14 explains her experience of being a general practitioner in the following terms:

you've got contact with the patient. You know their situation quite often you know their families, they'll probably tell you lots of problems they've been through because they've had the time if you're open to that sort of information they will tell you things that they won't tell anybody else. I mean some people say we're the modern clergy, I don't know if we are, I think GPs have always had that position and the other thing is people despite what is said in the press and the rest of it people still respect the doctor's opinion.<sup>36</sup>

As we can see this GP draws upon the rhetoric of the family and compares the role of the GP to that of the clergy (often described as being a central figure in the local community). This doctor also draws upon a notion of patient respect for the GP as one important characteristic of general practice which encourages close relationships between patient and practitioner.

As Bowling suggests, all these descriptions of general practice (based upon such rhetorics as relationships, community, artistic and intuitive doctoring) can be seen as the 'superficial definitions' of the profession.<sup>37</sup> She argues that these elements of definition are superficial in as much as they fail, if unaccompanied, to adequately demarcate a body of unique medical knowledge upon which general practice can consolidate its professional status, role and identity. However, she adds, such definitions 'may be of crucial importance in distinguishing between the role of the general practitioner and the role of the hospital doctor'.<sup>38</sup> Indeed, as we have already seen, some of the GPs do employ such rhetorical devices as intuitive and artistic practice as a means of demarcating their practice and identity from that of hospital medicine and hospital practitioners. However, we can also detect another important rhetoric which is drawn upon by the GPs to describe their professional identity - the

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<sup>36</sup> Dr 14.

<sup>37</sup> Bowling, A. (1981). *Delegation in General Practice*. London, Tavistock.



rhetoric of holism. As will be seen in the following sections this rhetoric is closely tied to the GPs' descriptions of their complementary practice and moreover, when employed in combination with the other rhetorical devices outlined so far, this rhetoric, in particular, helps to produce a much sharper and more effective boundary distinction between the GPs' practice and that of hospital medicine.

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<sup>38</sup> *Ibid.* pp.41-42.

## 6.4 The Rhetoric of Medical Holism

We all try and do you know try and practice the concept of holistic medicine but I think you know it depends what your holism embraces.<sup>39</sup>

Oh, I think any good GP is holistic.<sup>40</sup>

I think if you're in general practice then it's important to try and practice holistically.<sup>41</sup>

It should maybe come as no surprise to find these doctors appealing to the rhetorical device of holism in their explanations of professional identity.<sup>42</sup> Perhaps even less surprising is the GPs' appeal to holism in relation to their justifications for developing unconventional therapies. Indeed, a brief scan of the literature on these medicines reveals a constant reference to their 'holistic' nature or style of approach,<sup>43</sup> and some commentators have even chosen to use the title 'holistic medicine' in defining this whole field.<sup>44</sup> In addition, research has revealed that many lay therapists

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<sup>39</sup> Dr 9.

<sup>40</sup> Dr 12.

<sup>41</sup> Dr 7.

<sup>42</sup> Many writers and practitioners have appealed to this concept in their presentations of general practice. For example see, Pietroni, P. C. (1986). 'Holism, Complementary Therapy and Primary Care'. *Holistic Medicine* 1: 91.

<sup>43</sup> Sharma, U. (1992). *Complementary Medicine Today: Practitioners and Patients*. London, Routledge. Sharma, U. (1994). 'The Equation of Responsibility: Complementary Practitioners and their Patients'. In S. Budd and U. Sharma (eds). *The Healing Bond: The Patient-Practitioner Relationship and Therapeutic Responsibility*. London, Routledge. Saks, M. (ed.) (1992a). *Alternative Medicine in Britain*. London, Clarendon Press. Similarly, other writers have encouraged the use of this rhetoric through demarcating the practice of healing from that of curing. Young for example describes curing practices as efficacious in either reversing, limiting or preventing disease while he defines healing practices as efficacious from the point of view of the patient. Young, A. (1983). 'The Relevance of Traditional Medical Culture to Modern Primary Health Care'. *Social Science and Medicine* 17: 1205-1212. Both Fitzpatrick *et al.* and Kleinman have highlighted how traditional health care deals with 'healing' while biomedicine tends to gear itself only to curing, see Fitzpatrick, R., Hopkins, A. and Harvard-Watts, O. (1983) 'Social Dimensions of Healing: A Longitudinal Study of Medical Management of Headaches'. *Social Science and Medicine* 17: 501-510. Kleinman, A. (1980). *Patients and Healers in the Context of Culture*. London, University of California Press.

<sup>44</sup> Berliner, H. S. and Salmon, J. W. (1980). 'The Holistic Alternative to Scientific Medicine: History and Analysis'. *International Journal of Health Services* 10(1): 133-47; Berliner, H. S. and Salmon, J. W. (1979). 'The New Realities of Health Policy and Influence of Holistic Medicine'. *Journal of Alternative Human Services* 5(2): 13-16. Stalker, D. and Glymour, C. (1989). *Examining Holistic Medicine*. New York, Prometheus Books. Saks, M. (1994). *Op. Cit. No. 43*. Indeed, Saks employs the concept of holism as a means of contrasting alternative and conventional medicine. He writes of 'the biomedical principles underpinning the activities and professional standing of medical orthodoxy, in which the body tends to be viewed as a machine whose parts can be repaired on breakdown', and he

perceive their practice in holistic terms and that they often employ this rhetorical device as a means of demarcating their work and role from that of the general practitioner.<sup>45</sup> Some social scientists have gone so far as to underwrite these claims.<sup>46</sup> Given the extent to which claims to employ a holistic approach are mobilised by practitioners outside the medical profession, it is interesting to examine how GPs construct the concept of medical holism. As this section explains, the GPs often employ what would appear to be exceptionally shrewd constructions, which can be seen as part of wider ideological strategies to direct the processes of legitimacy and authenticity such that 'complementary' therapies are appropriated for use within general medicine.

As Richenda Power has shown, there is a noticeable confusion between claims as to what constitutes 'holism' in medicine.<sup>47</sup> Power refers primarily to the difference between the claims of medical groups such as doctors and lay therapists. The analysis presented in this chapter illustrates the different constructions of this concept within

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contrasts this to 'the characteristically more holistic approach of alternative practitioners operating largely outside the orthodox profession who show a greater degree of recognition of the importance of the relationship between mind and body in individual diagnosis and treatment', p.85.

<sup>45</sup> Power, R. (1984). 'Naturopathy'. *Self & Society* 12(1): 6-9. One homeopath in Cant and Calnan's interview-based study is quoted as describing his homeopathy as: 'a holistic medicine, we deal with the mental and physical systems; the underlying emotions bubbling around. If you haven't got anything physical, it's very hard for a GP to deal with you'. Cant, S. and Calnan, M. (1991). 'On the Margins of the Medical Marketplace? An Exploratory Study of Alternative Practitioners' Perceptions'. *Sociology of Health and Illness* 13(1): 39-57. p.46. In addition, Power also provides supporting evidence as found within the claims of elite alternative medical associations. Power, R. (1997). 'The Whole Idea of Medicine'. *Medical Sociology News* 23(2): 39-50.

<sup>46</sup> Douglas, M. (1994). 'The Construction of the Physician: A Cultural Approach to Medical Fashions'. In S. Budd, and U. Sharma (eds). *The Healing Bond: The Patient-Practitioner Relationship and Therapeutic Responsibility*. London, Routledge. As Douglas writes of medical holism, 'Present-day medical holism is a philosophy of the body which does not grow out of the history of Western medicine. Otherwise you might say that our family doctor takes a holistic view of medicine'. She later adds, 'I personally appreciate having the diagnostic resources of Western medicine placed at my disposal. But this is not at all what is meant by medical holism. Our doctor's holism stops at the boundaries of the body and stays within the boundaries of the medical profession, whereas holistic medicine takes global account of the patient's whole personality and spiritual environment', p.24.

<sup>47</sup> Power, R. (1997). *Op. Cit. No. 45*. Also see Vickers, A. (1993). *Complementary Medicine and Disability*. London, Chapman and Hall. He states, 'holistic is a tricky word and it often comes to mean whatever a speaker wants it to mean', p.4. Likewise Kirk and McLean also acknowledge the spectrum

the particular professional community of general practice. There are basically two different constructions of holism given by the GPs in the study, some doctors employing both while others presented only one of either.

#### 6.4.1 Treating the ‘Whole Person’

Holism’s about not taking symptoms in isolation you know it’s about you know seeing the whole person in front of you.<sup>48</sup>

Many of the GPs interviewed talk of the importance of treating the ‘whole person’. This, the GPs suggest, involves perceiving illness as more than simply the symptom presented in the surgery. Instead it involves relating illness to social relations and to the social and cultural factors embedded in these relations.<sup>49</sup> As one GP explains, ‘holistic’ general practice ‘involves looking at an individual in his environment. Not just his physical but his psychosocial environment, his relationships, his attitudes, his beliefs, his values’.<sup>50</sup> Another claims, ‘I would like to think I had an holistic view of the patients...I mean it’s not difficult because the patients are all one person and the why they are ill and the what particular illnesses, and why they are ill at this particular time is all related to their background and upbringing and their marital status and work situation’.<sup>51</sup>

As Stimson affirms with regard to general practice, employment of the term ‘social’ and a reference to ‘non-clinical’ aspects of practice are frequently ambiguous

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of meanings associated with the concept of holism in medicine. See Kirk, S. and McLean, J. (1987). ‘Can Holistic Medicine Work in General Practice?’. *Holistic Medicine* 2: 217-226.

<sup>48</sup> Dr 13.

<sup>49</sup> See Armstrong, D. (1979). ‘The Emancipation of Biographical Medicine’. *Social Science and Medicine* 13a: 1-8.

<sup>50</sup> Dr 18.

<sup>51</sup> Dr 2.

and can often relate to a number of diverse issues.<sup>52</sup> In line with this claim we can detect two interwoven yet distinct conceptions of the patient from within these GPs' accounts. The first is based upon an exploration of the personality and immediate observable behaviour of the patient and the second on an understanding of the patient in social and environmental context.

In the first approach cues are dealt with throughout the process of the consultation itself. Some GPs outline the significance of body-language and observing the 'general look' of the patient before them. They also emphasise how complementary medicines have developed as a form of care geared towards such observation. As one GP explains in relation to her practice of hypnotherapy and neurolinguistic programming, 'you're watching their body language all the time, you're watching what they're doing'.<sup>53</sup> The following GP describes her homeopathy and how she perceives her observation of patients as implicit within her homeopathic practice and prescribing. She states:

Pre-menstrual syndrome or pre-menstrual depression is probably a case in point because you can have a woman that comes in and she's very sort of bright and bubbly and talkative, but she's telling that she's got dreadful times - she's irritable, terrible to live with in the week leading up to her period - her

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<sup>52</sup> Stimson, G. V. (1977). 'Social Care and the Role of the General Practitioner'. *Social Science and Medicine* 11: 485-90. Stimson outlines these issues in more detail as doctor-patient communication; an awareness of social welfare problems of patients; the GP's role in treating emotional problems, amongst others. For similar discussions of the term social relating to general practice see Mechanic, D. (1970). *Op. Cit. No. 5*.

<sup>53</sup> Dr 5. Another GP (Dr 17) also presents a similar characteristic of neurolinguistic programming which is based upon close observation and body language. He states, 'As far as general practice is concerned even in the consulting basis like this now you will observe how you're sitting with your left leg crossed over your right leg and I'm sitting on my left leg crossed over my right leg and your shoulders tilted a bit and my shoulders tilted a bit and we're speaking at the same rate and same sentence length and all these things, these are all techniques that you learn in NLP. When I ask people questions I will observe how their eyes move. I will listen to the way they talk I will listen to what words that they use and if they're predominantly visual or kinaesthetic or auditory in the words that they use and try and achieve a rapport...observational techniques in NLP are really important if I want to know if something is bothering somebody and then the way, you have lots of signals and lots of cues as to what's going on in their mind, and it's not the case of mind reading, it's a case of just seeing how they process information. If I ask them a question and I see that they're looking up and to the left then it's very likely that they are accessing visual information from the past, auditory information tends to be in a different area and internal dialogue you tend to look down on the left when you're talking to yourself internally'.

husband's ready for divorcing her at that time of the month and he said go down to the doctor and get something. And there's other women that come in and they just feel totally washed out and everything's getting on top of them. Now, the first woman who comes in has got herself done up and she's a different type of woman who drags in the door looking like death wearing yesterday's clothes

Interviewer: And you are perceiving these things?

Oh yes, and her hair hanging round her ears and the kids dragging her through and she says I just feel really down, you see just before my periods I just can't be bothered and that's a totally different person and it's a totally different remedy<sup>54</sup>

And another homeopathic GP describes her therapy in direct terms of personalities. She explains, 'it delves more into what the particular patient is like and what aspects of their character and personality, erm, trying to draw these together or erm, even single out one that would, could approach or try and give a treatment'.<sup>55</sup> These extracts illustrate the close relationship within some of the accounts between the suggestion that complementary therapies encourage a closer observation of the patient and the notions of idiosyncratic practice explored earlier.

Dr 12 also projects patient personalities as an authentic concern of general medical practice. He states:

you've to take into account the person's personality, you've to take into account exactly what they say. You know you've to listen quite intently because everything they say is very important. Whereas one of the things about being a GP, as a normal GP, is that you have to focus in on things quite quickly so you've to cut out everything and then you just narrow it down so from a homeopathic point of view you've to kind of widen it and it creates more questions.<sup>56</sup>

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<sup>54</sup> Dr 6.

<sup>55</sup> Dr 21. Likewise Dr 10 portrays her homeopathy as 'whole person' medicine. She states, 'in homeopathy more of an interest is taken in the patient as a whole person'.

<sup>56</sup> Dr 12. This same doctor goes on to further explain this difference between homeopathic consultations and 'normal' general practice. Here the GP talks of being in 'different modes': 'if the patient comes in and they say something, if you're in a homeopathic mode you may have to ask other questions and broaden it out more and then ask them well what happens when you take this or what type of weather affects that or as opposed to in standard medicine you just want to focus in...so there's the contrast between broadening things out and being very focused as a GP'.



This doctor draws a contrast between, on the one hand, the interest allocated to the patient's talk and interpretation of their complaint which is employed in homeopathic consultations, and to that style of investigation traditionally found in general practice on the other. He suggests that everything the patient says is important and claims this links to the need to expand awareness of the patient beyond the model advocated within traditional general practice. In this presentation homeopathy is explained as widening the scope of general practice and as providing the tools with which a more detailed examination of the patient can be conducted.

The second aspect of the construction of the whole person found within the accounts - one which links with the notion of the whole person just outlined - is at the level of the social or environmental sphere. It involves consideration of how this environment affects and intertwines with the patient and their illness complaints. Some GPs clearly describe their complementary therapies in line with the exploration of and close attention to these 'social', psychological and other circumstances which are seen as central to holistic practice. The following extract from one GP's talk illustrates how she presents her complementary therapies (autogenic training, homeopathy, hypnotherapy and neurolinguistic programming) as focusing upon these 'social' factors relating to patients' wider lives. She says:

well for hypnosis, phobias for example, there is no way anything is going to alter a phobia unless you get sorted out where it has come from and people will come in and they've got a lot of anxiety, maybe a remark someone made. Well, with neurolinguistic programming you can just in one minute get rid of that and it stops the constant replay, with autogenic training it is teaching them total awareness that in your day-to-day work you have a method of dealing with the emotions and the feelings and you can give them an exercise to deal with the anxiety, an exercise to deal with the anger and an exercise to deal with grief. Homeopathy for instance like grief that is more prolonged, erm, where people aren't coping or even just an immediate grief reaction the



homeopathic drugs are wonderful, it's just they work so well and allow people to be able to cope with what's going on in their life.<sup>57</sup>

Here the therapies are presented as effective in dealing with aspects of illness which can only be located through a close inspection of the patient's talk; there is a need to understand where phobias, anxiety and the like 'come from'.

Another doctor practising acupuncture stresses his 'wider' concerns and medical gaze when employing acupuncture in his practice: 'when I'm treating somebody with acupuncture then I'm not not specifically just treating their pain. I'm hoping that I can help other parts of them as well and I'm certainly talking to them about other parts in their life at the same time'.<sup>58</sup>

These doctors above (Dr 5, 13 and 19) present their therapies in holistic terms, at least in the sense of encouraging individualising treatments. As another GP declares: 'that's what homeopathy's all about, and all the other holistic type medicines, er, therapies, they're about individualising the treatment'.<sup>59</sup> Others express a similar perception of medical holism in terms of treating a *person* rather than simply a *patient*. These doctors suggest that treating an individual as a patient leads to an 'unhealthy' focus upon disease and a failure to acknowledge what they see as the complex and multi-layered nature of illness.<sup>60</sup> Dr 7 highlights the use of this particular rhetorical device when she explains her homeopathic practice as holistic. She states:

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<sup>57</sup> Dr 5. The talk of doctor 13 reveals the use of similar rhetorics when she explains her homeopathy and hypnotherapy: 'it's taking on board the whole thing and we'll often know the family set up and the supports that are around there so it's trying to approach the problem in such a way that the person's going to be able to handle it'.

<sup>58</sup> Dr 19.

<sup>59</sup> Dr 8.

<sup>60</sup> For example Dr 7 says of her homeopathic practice: 'I think homeopathy makes you more aware, to use that term, to be holistic and to sort of look at the patient and say now well tell me about this, what's been going on here, you know, you're not just seeing that Joe Bloggs has got a sore head or Mrs So and So's been in three times in the last week with a sore toe, you know, you say, I wonder what's going on, I mean GPs do that anyway, but I think it makes you more aware'. Dr 14 explains this concern to demedicalise patients and treat them as people rather than as disease categories with regard to her practice more generally. She explains it like this: 'People walk in the door and they don't walk in the

I think homeopathy has definitely made me more aware of the patient as a person. I mean even though maybe general practitioners who have been in general practice for a long time become more aware of that but I think it does give you a more holistic approach. I think it just does give you a more holistic approach you know a more personalised approach in that you're looking at your patient as a person.<sup>61</sup>

Many of the GPs talk of patients' clusters of problems, of 'teasing out', of 'weeding out' or getting to the 'root cause' of medical problems and of 'peeling back the layers' of illness.<sup>62</sup> As one GP states:

Well, I suppose the big thing in general practice is that people may come with a sore ear but they may in fact be depressed. If you just look in their ear and say well have some amoxil then you're never really going to deal with the problem.<sup>63</sup>

Dr 17 also talks of 'something else' bothering some patients and how he sees the attempt to uncover such hidden problems as central to much of his general practice:

If I'm going to treat the patient with a symptom and treat the symptom then by and large that patient may get better but the way I view the patient as an individual in the context of which he's living must alter my perception of him as a patient. I'm gonna treat, I'm not saying that if somebody comes in with tonsillitis I'm not going to be delving into the fact that he's not getting on with his wife and his boss is a bastard and so on I'm gonna be treating his tonsillitis. But there are many other situations where you find that they'll come in with something but it's something else that's really bothering them.<sup>64</sup>

And as another GP conceptualises certain forms of illness, 'there are patients who have complex psychological problems dressed up as physical complaint and I think in those circumstances they often get quite good results by, you know, tackling one

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door as an illness. I don't regard people as their illness right so I would try and avoid calling patients say diabetic because they're not, they are a patient who has diabetes it's a small facet of their lives...in medicine I think we actually make people become the disease and I think that's wrong'. Interestingly, this gaze beyond the immediate physical complaint has been employed by alternative therapists as a means of demarcating their practice from that of GPs. See Cant, S. and Calnan, M. (1991). *Op. Cit.* No. 45.

<sup>61</sup> Dr 7.

<sup>62</sup> These are phrases employed by Drs 4, 8, 1 and 5 respectively.

<sup>63</sup> Dr 1.

<sup>64</sup> Dr 17.

aspect of their, of their presentation at a time'.<sup>65</sup> Dr 5, practising homeopathy amongst other therapies, draws upon similar rhetorical devices as a means of describing her homeopathy and how it can be used to provide a deeper exploration of the patient and their illness. She states, 'something that's been long standing you're having all sorts of layers and they talk about homeopathy taking the layers of onions off, layers off an onion, solving bits each one it takes time to get all these layers undone'.<sup>66</sup> In addition, Dr 7 highlights how homeopathy may be used to approach 'what else is going on' behind the initial complaint. She says:

If you think that you know this lady's in two or three times and there's not much to her cough you might think what else is going on here and in the same way that you might know from before and you think ah I think there's something might be going on here and you say how would you like to come back and see me some time and I'll do a homeopathic history.<sup>67</sup>

One doctor refers to the discourse of intuition in her description of how the doctor is to detect the 'nub' of the patient's problem:

I would have to say that there are different, there are doctors that are more intuitive, that follow their feelings, their gut reactions about patients, that even if they're going down a certain line, you know, you might be saying well this woman's got hyperthyroidism? So, I'll do a blood test, that blood test and the next blood test, but there's something else about that patient. There's a problem, and you can go down the line and you can treat the hyperthyroidism but you're not getting to the nub of the problem with the patient. Now, I tend to get side tracked by these things. I would treat the patient for a hyperthyroidism but then I would ask them about something and I might find they've got a basic problem. A big problem in their life or whatever as well and I'll start to go down that track too and that's different, it's making work

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<sup>65</sup> Dr 21.

<sup>66</sup> Dr 5.

<sup>67</sup> Dr 7. Dr 13 employs a similar discursive device in her description of homeopathy and a whole range of alternative therapies offered in her group practice. Here again these therapies are presented as useful in dealing with hidden or deep rooted medical complaints. She says: 'when there are other factors you know if they've got a complicated situation, if they've got multifactorial diseases and that and I think if you're seeing people and alarm bells are ringing, if you're seeing the same person umpteen times for trivial stuff you know what's going on here and that alerts you and I think within the practice here we are terribly lucky because we are able to use a range of alternative skills to things if people do need a different approach to things then you're able to offer it whether it be homeopathy or whatever'.

for yourself basically but at the end of the day if the person feels, well, they're not treating my symptoms, I did need to talk to someone<sup>68</sup>

As we can see from these quotes, the 'real' medical problem is in some cases regarded by these GPs as lurking beyond the physical symptoms presented by the patient. In order to tease out this 'root' problem and be able to deal with it effectively requires, so the GPs suggest, a more penetrating exploration of the ill patient; an exploration which involves delving into these other realms of the whole person. This perception of illness as multi-layered and as more than simply physiological symptoms ties to what most of the GPs presented as the role of their complementary therapy in practice. To return to the talk of GP 5:

Interviewer: So where does the homeopathy fit in?

Well, I think it's not just treating a symptom or a pain it's dealing with the whole person...it's, I think, to do with the actual interview but also to do with, you know, trying to find out what the root cause of the problem is.<sup>69</sup>

Another GP suggests:

what I have found is that there are patients that are coming in general practice and they were given, they'd have standard treatment, standard medical treatment and the problem was failing to get better or improve, if anything deteriorating and there is usually something behind that that you need the complementary therapies to sort out.<sup>70</sup>

The therapies are often explained by the GPs as encouraging longer consultations (although time constraints in general practice were seen as a major limitation to incorporation as shown in the proceeding chapter), they talk of a deeper exploration of the patient's biography and social environment and closer physical contact with patients. As a GP explains her practice of homeopathy:

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<sup>68</sup> Dr 6.

<sup>69</sup> Dr 5.

<sup>70</sup> Dr 8.

Well, it suddenly, well it gave me an, a lot of the patients I knew I found I didn't know at all. I discovered things about people I didn't know, because once you start asking questions in a homeopathic way people started to open up and tell you things that had happened to them years ago and tell you about their life circumstances and things like that that I didn't know about.<sup>71</sup>

And Dr 15 describes the role of the therapies in his general practice in comparable terms: 'they just allow me ways of relating to people which is nearer their core you know their core than allopathic medicine, you know than listening to history and listening to a chest and giving an antibiotic'.<sup>72</sup>

In a similar sense, the following homeopathic GP explains how his homeopathy involves 'a deeper questioning, a deeper enquiry and history-taking'.<sup>73</sup> As he explains:

When you take a homeopathic history you have to enquire about the nature of the illness, the extent of the illness, the depth of the illness and the flow of the illness and the effects outside agencies have on it - changes in the weather, changes in the environment, lying down, sitting up, sleeping, walking, talking, exercise, going upstairs, going downstairs - all things like this, things that they eat, do these things have an effect? It's just a very deep enquiry.<sup>74</sup>

And one GP acupuncturist explains how he perceived his acupuncture to be more 'patient-centred' than his conventional treatments:

Inevitably for some time you focus in on the patient more and you're more interested, you're more intensely interested in the symptoms and more intensely interested in the patient which I'm sure is quite beneficial. I mean

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<sup>71</sup> Dr 6. Dr 7 employs similar rhetorical devices to describe the character of her homeopathic medicine in practice: 'what I find quite useful about the homeopathic consultation proper is that you really get to know your patients very well. You get to know things about your patients that you didn't know before Interviewer: Can you explain that for me?

Well, I had one woman who actually came and said to me could I treat her homeopathically and I'd been seeing her. I've been seeing her for seven years and I'd seen her quite frequently, very quiet lady and it's when you start the homeopathic history and you learn that she was widowed very young, you know, the problems she had bringing up her children and all these sorts of things that had happened to her in her life and I think it gives you a better appreciation of your patients'.

<sup>72</sup> Dr 15. Dr 10 explains how complementary therapies are a means by which GPs can take their patients seriously and are able to develop a 'wider context' to care. He says: 'I think perhaps the therapies from the patient's point of view show that you're willing to look at things in a wider context, a wider context of, you know, not just walk in the door and you're writing the prescription on the line as they walk in but you're actually taking an interest in them'.

<sup>73</sup> Dr 8.

<sup>74</sup> *Ibid.*

they like the extra attention, they like the fact that I was suggesting something else that might work, erm, so there was, there was a sense that I was more involved in the patient over that period.<sup>75</sup>

So we can see from the extracts analysed in this section so far that these GPs portray complementary therapies as tied firmly to notions of holistic practice. However, as we shall see in the next section, this does not necessarily lead to the suggestion that complementary medicines lend anything particularly novel to general practice.

#### 6.4.2 Enhancing Holism

I find this idea that homeopathy is holistic and non-alternative therapies aren't, I find that very, that's an artificial division.<sup>76</sup>

The whole idea of general practice is that you're looking after the whole person anyway, which is a homeopathic sort of concept that you're looking after the whole person and not just the disease...I mean you don't see, oh here comes this gallbladder coming in the door you're seeing it as Mrs So and So and her kids and her Auntie and her granny, Uncle Tom Cobley and the whole bit.<sup>77</sup>

Many of the GPs are keen to stress that a holistic approach did not evolve simply with their development of complementary practice. They talk of always having been holistic and how holism is not confined to complementary medicines. As one GP states, 'I think general practice is holistic but then to my mind [the word has] been hijacked by people who do complementary medicine who claim that their style of medicine is holistic'.<sup>78</sup> Dr 2 also touches upon this issue in his account:

I feel you've got conventional medicine here and this holistic approach to the person, to their body language, to their needs, and just treating the person not just as a knee or a hysterectomy but as a person who has needs and requires support and counselling maybe, sympathy, understanding, a listening ear and

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<sup>75</sup> Dr 4.

<sup>76</sup> Dr 25.

<sup>77</sup> Dr 16.

<sup>78</sup> Dr 15.



then from that you can start including the other things like acupuncture and homeopathy and so on, they fit in very well with the concept.<sup>79</sup>

In this description of the location of holism in relation to both conventional and unconventional treatments the GP acupuncturist suggests holistic practice is possible prior to integrating complementary treatments; conventional general practice can already be holistic and complementary therapies build upon and help encourage such an approach to health care. By the same token Dr 20 claims both conventional and complementary medicine are holistic and that they simply provide different contributions to this end. Here he talks of complementary therapies adding another dimension to his holistic practice. He says:

hopefully complementary medicine just adds another dimension to help, help people in life achieve wholeness. You know I think, I mean conventional medicine can achieve, I think, wholeness and I think complementary medicine can achieve as well, they are just different approaches towards it.<sup>80</sup>

And another GP acupuncturist also describes holism in these wider terms. He says:

I would hope that I always....that the prescription is given in context. I always try and, hmm, getting a feeling for the full kind of, well, you can fit it into the teachings of, on these things of psychophysical, psychological, psychosocial environment of the patient. I try to make sure that the prescription fitted into that, hmm, for instance if somebody came in with an ear infection I would not just without speaking give a prescription for antibiotics and show them the door. I would discuss what, what an ear infection was, why the antibiotics might or might not work, what other things they could do to help themselves in the meantime, you know, how they might prevent it coming back again in the future, that sort of thing, hmm, and maybe a little bit about whether or not they should have an antibiotic at all and try to get them involved in that discussion and then yes a prescription is part of that and is a necessary part.<sup>81</sup>

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<sup>79</sup> Dr 2. Another illustration of this rhetorical claim is found in the talk of Dr 18. He says, 'really by definition all medicine is holistic. I mean any therapeutic relationship should be seen as holistic, should be seen as involving physical, mental and social aspects of an individual. I don't think orthodox medicine should be seen as non-holistic anymore than psychotherapy should or acupuncture should for example'.

<sup>80</sup> Dr 20.

<sup>81</sup> Dr 19.



For this GP, like the others quoted in this section, holism does not relate simply to the type of therapy employed but to the *style* of medicine cultivated. In these terms, he describes how the routine prescription-making of general practice, if undertaken in the appropriate manner, can also be seen in the context of an holistic approach. This formulation of holism, as extending beyond the realms of complementary therapies, shares some similarities to that of the British Holistic Medical Association founded in 1983 by a group of general practitioners. As the Chairman of the Association, Dr Pietroni, claims in a journal editorial of 1984, 'holistic medicine is concerned with how one practises medicine, not what branch of medicine one practises'.<sup>82</sup> It is interesting to find that these claims have also permeated the grass-roots of general practice and are being employed by GPs integrating complementary therapies for particular ideological effect.

The GPs' claim to having been holistic prior to the adoption of complementary therapies also provides a means with which these GPs present their general practice as a suitable context for the therapies. Moreover, the rhetorical devices mentioned earlier - social relationships, intuition, the artistic element of medicine and the like - are also employed as illustrating the suitability of general practice as a site for incorporating complementary therapies. However, these rhetorical devices when employed in

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<sup>82</sup> Pietroni, P. C. (1986). 'Holism, Complementary Therapies and Primary Care'. *Holistic Medicine* 1: 91. In addition, Jarman writes, 'it is unfortunate that the word holistic has been linked with "alternative medicine" for the term is not about a method of treatment but about an approach', he claims (from within general practice); 'the holistic approach to health and disease is equally found amongst orthodox medical practitioners as amongst alternative practitioners', Jarman, B. (ed.) (1988). *Primary Care*. London, Heinemann, p.147. Rosenberg, C. E. (1998). 'Holism in Twentieth-Century Medicine'. In C. Lawrence and G. Weisz (eds). *Greater Than the Parts: Holism in Biomedicine 1920-1950*. Oxford, Oxford University Press. Power has identified different formulations of holism, one being what she calls professional claims. Professional claims, she suggests, are where the professional group, either medical or lay, present holism as synonymous with their established practice or therapy. Power gives the example of naturopathy, which some therapists have defined as the original holistic therapy. While there is a convergence with the analysis here, Power would seem to have a more restricted approach than my own to the ideological function of language. I would ultimately suggest that all such presentations, whether they be in texts (formal or informal) or talk, are open to ideological analysis. See Power, R. (1997). 'The Whole Idea of Medicine'. *Medical Sociology News* 23(2): 39-50.

conjunction with a holistic rhetoric, help locate holistic practice, and thereby complementary therapies, firmly within the environment of general medicine.

#### 6.4.3 Holism in Terms of Generalism: Quantity Rather than Quality

I think any form of general medicine where you are looking after the person as a whole person or within a family or within a community is holistic when you can hopefully offer as many different forms of therapy as possible.<sup>83</sup>

I perceive general practice as a whole as holistic...in terms of how you tend to, how you approach helping with that medical problem, you know, the world is your oyster, you can do it any way you like, so general practice is holistic.<sup>84</sup>

As mentioned earlier, we can also distinguish another formulation of holism from within the accounts. This construction - deployed by a smaller number of GPs - is in most cases employed alongside the claims of treating the whole person. Interestingly, this second presentation also acts to augment the definition of holism as shown previously, and the GPs' construction of a boundary between general practice and hospital medicine. As one GP explains his understanding of the concept of holism:

if someone can claim that they can deal with ninety, ninety-five percent of any medical problem or attempt to deal with ninety-five percent, and also perhaps look after the patient within the wider setting of the family and the community then that's holistic medicine.<sup>85</sup>

And another practising acupuncture puts it like this:

I would say that a holistic approach just includes everything, it doesn't exclude anything....I mean, I include [acupuncture] where I think it's appropriate...I mean I'm not trying to move into a different like frame of treatment and think only of acupuncture and not Western medicine. I mean I would see it as less

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<sup>83</sup> Dr 4.

<sup>84</sup> Dr 1.

<sup>85</sup> Dr 18.

holistic to offer somebody only acupuncture and ask them not to use western treatment.<sup>86</sup>

These descriptions of holism centre attention not upon the content or style of different therapies, whether they be conventional or otherwise, but instead define holism in direct relation to the range of skills and treatments a practitioner has at his or her disposal and the proportion of problems they can treat.<sup>87</sup> In these accounts holism is quite blatantly constructed as synonymous with generalist medicine; a position which obviously excludes the specialist treatment of hospital medicine and the practice of lay therapists who are also perceived as specialists by these GPs.<sup>88</sup> Yet, despite complementary therapies not being necessarily seen as holistic in themselves, they are often credited with a central role in developing holistic general practice. This is because, according to the construction of these GPs' accounts, holism is by definition the application and mixing of more than simply one approach to medicine; integrative practice is promoted as the ultimate holistic form of medical practice.

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<sup>86</sup> Dr 19.

<sup>87</sup> This claim has also been put forward from within more formal medical literature, see Jarman, B. (ed.) (1988). *Op. Cit. No. 82*. p.142.

## 6.5 Hospital/GP Boundary-Work

As we have seen on a number of occasions so far in this chapter some of the GPs employ the range of rhetorics with which they portray their professional identity as a means of demarcating themselves from hospital medicine. As this section will now illustrate in more detail these rhetorics, either in isolation or in combination, often provide a particularly useful resource for accomplishing such boundary-work. Moreover, this section also shows how the incorporation of unconventional therapies is used by these GPs to accentuate the demarcation between general practice and hospital medicine.

### 6.5.1 Drawing Upon Notions of Social Relations, Continuity of Care and the Whole Person

I had a lady in this morning with pains in her chest and I'm actually sending her down to get, to be seen by the cardiac assessment clinic tomorrow. But we talked about the fact that her job has gradually become more stressful over the years. I brought in the issues of stress and it's probably that that's causing her physical symptoms. The hospital will see her and they will go through the battery of tests and they will say there's nothing wrong with your heart, I expect, you know, end of story. But, you know, the lady still has a problem. Well the breadth of the scope here is the breadth of the patient's problem, you've no real border, you've no real defining line.<sup>89</sup>

I'm looking at an individual as a person in an environment surrounded by home and family and community. Looking at how they fit into that environment as opposed to seeing an interesting biochemical abnormality, third bed on the left. So, I think there's a lot more of the art of medicine which can be practised in general practice. It's not to denigrate the hospital practitioners, but they have a totally different constraint in which they have to operate.<sup>90</sup>

One particular collection of closely linked devices which are drawn upon by many of the GPs to create distance between general practice and hospital medicine are those pertaining to having social relationships with patients, knowing the wider social

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<sup>88</sup> Refer to chapter four for discussion of this presentation of lay therapists as specialists.

<sup>89</sup> Dr 1.

context of patients outside the surgery and consequently treating the patient as a whole person. We can identify the employment of a number of these devices in the following extract from an interview with a GP homeopath. She states:

if you get someone in hospital you maybe see them a couple of times at an outpatient clinic. You take them into the ward, you flip out whatever the problem is, you start them on the treatment and you maybe don't see them again...[whereas general practice] is more, you know, you're in their houses and you speak to them and you know their granny...you know people and that makes a big difference to how you treat them. I mean if you know that they've got an alcoholic husband and if they come in and say they're depressed you won't automatically give them an antidepressant you know, you'll start to look at other things.<sup>91</sup>

This talk utilises an image of hospital medicine commonly drawn upon across the accounts. It describes hospital medicine as lacking any continuity of care; a continuity which is often contrastingly highlighted by the doctors as a defining feature of general practice. For example Dr 4 describes his motivation for entering general practice as follows:

I chose to do medicine a long time ago now and I haven't regretted it. I think it's a, I like the idea of trying to help people, erm, the, there's some, it's easier to do that over a long period of time in general practice than it is virtually in anything else because you've got close intimate contact with people off and on over many years.<sup>92</sup>

In addition to drawing upon notions of continuity of care to demarcate general practice from other branches of medicine this GP's talk also presents general practice as patient-centred. In this quote, as we have seen on numerous occasions previously in the analysis, general practice is portrayed as having the interests of patients as a motivation - if not *the* primary motivation - behind practice.

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<sup>90</sup> Dr 24.

<sup>91</sup> Dr 25.

<sup>92</sup> Dr 4.

Another GP, practising homeopathy, explains why homeopathy and other therapies are more widely accepted in general practice than in other branches of medicine:

...as open and innovative and broadminded and, er, ...accepting of any, any, treatment option that comes along, which doesn't mean that, you know, anything you read about you say, you know, you must try this, but I think you have to be, you have to consider your patients' best interests and be as, be as well informed and as empathic to their needs as you can be and if you can bring special knowledge of a, of any other speciality into that then all, you know, well and good.<sup>93</sup>

Once again we can see how such talk places the patient's interests at the very heart of general medical practice. Here imagery of altruistic practice is tied directly to the incorporation of unconventional therapies. More specifically, the decision to practise unconventional therapies is not presented as governed by prejudice or self-interest but instead presented as the result of objective and unbiased appraisal of patient needs. As we shall see a little later in this chapter, this style of argument is commonplace across the accounts with many GPs describing the very incorporation of other therapies within general practice as a sign of the relative open-mindedness and patient-centredness of this branch of medicine especially when compared to hospital practice.

Many doctors supplement their talk of social relations and continuity of care within general practice by contrasting this with presentations of hospital medicine as concentrating solely upon the disease entity. In effect, the combined use of these contrasting descriptions, helps produce a stark distinction between the two types of medicine. For example Dr 10 claims:

I thought oh I want to be a surgeon, I want to be them but you're standing around for hours you know poking around doing an appendix, it's not exactly the same thrill and but the surgeons would then say to, hello Mrs so and so from the end of the bed, you know, and how's the boil today? Fine? OK, off

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<sup>93</sup> Dr 9.

we go and you'd. I felt there's nothing to this, I mean it's doing but it's not actually and the patient was away and the surgeon got them in, cut it out and took them out the door and that was it, the patient's gone, let's get on the next one. You know, that wasn't what I was looking for in medicine and I thought no this isn't for me.<sup>94</sup>

And the same GP later adds, 'I just felt the patients were real people and when they came into hospital they were no longer ill people, they were, they were diseases, and they were in their pyjamas and there was nothing more to them and it kind of why I went into general practice and the homeopathy'.<sup>95</sup> Here this GP utilises this description of hospital medicine as focusing upon the disease to not only demarcate this style of medicine from general practice but also from homeopathy. This presentation incorporates two related ideological tasks: on the one hand, this talk illustrates how the hospital/GP divide provides further opportunities for these GPs to authenticate complementary therapies within general practice; on the other hand, the talk also reveals how unconventional therapies are themselves employed as one particular resource with which to elaborate the hospital/GP border.

Dr 14 also contrasts hospital medicine with general practice through an explanation of the former as concentrated upon the disease rather than the person. She describes hospital medicine and hospital doctors in the following way:

...they're there to deal with an illness, they're not there to deal with the patient. They've been trained and that's why I say medical training does close you down a bit. If you're a specialist in cardiology then you're interested in hearts, end of story, the patient becomes somebody that you're interested in because of the disease. In general practice you might have a rapport with a patient for lots of reasons, their illness is the reason for them coming if they have an illness. I mean sometimes they don't have an illness as such but I

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<sup>94</sup> Dr 10. Dr 1 also outlines the distinction between the two sites of medicine with reference to his medical training. Here the GP draws upon the discourse of science and an overly-clinical approach as a means of characterising hospital specialisms. He states, 'I think while I was doing my training gradually I came to think that what I wanted to do was general practice rather than any hospital speciality which certainly the clinical ones tend to be more scientifically-based'.

<sup>95</sup> Dr 10.



think that the reason for contact at hospitals is because the person had an illness and therefore almost the person becomes the illness.<sup>96</sup>

Drs 23, 25 and 10 all provide talk which incorporates some of the devices discussed so far in this section. For example Dr 23 says:

In general practice when the person comes in you have to treat the whole person anyway, so I don't think acupuncture is any different from that because the patient is a whole person. It's not like being a specialist in hospital where if you refer to the gastroenterologist they will deal purely with the bowel and nothing else. In general practice we have to deal with everything that they have - their physical state, their psychological state and obviously their psychological state is important as well.<sup>97</sup>

This quote constitutes another example of how unconventional therapies are drawn upon by the GPs in their boundary-construction between general practice and the hospital. Moreover, as with previous extracts analysed in this section, the doctor explains the specialist care in hospitals as orientating around one particular strand of expertise rather than taking a wider scope for treatment.

Dr 25 outlines a similar distinction between general practice and hospital specialisms. Again, this is a distinction which not only incorporates but is built upon the location and nature of unconventional therapies:

homeopathy...it's looking at the whole person and their past, their present, their relationships, their preferences. You gain that in a primary care setting which you do not, I don't think you gain that at all in a secondary specialist setting...but you've got snapshots, what you get in a secondary sector is you get snapshots of people.<sup>98</sup>

And Dr 10 suggests:

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<sup>96</sup> Dr 14.

<sup>97</sup> Dr 23. Dr 14 uses comparable terms: 'I don't think consultants are holistic most of them. I have had some patients who come back really a lot worse from hospitals. Their physical condition may be addressed and some interesting stuff where in fact the patient's been given very negative suggestions because somebody's been taught a bit of communication and doesn't understand actually how to use it properly'.

<sup>98</sup> Dr 25.

more of an interest is taken in the patient as a whole person with [homeopathy] and the method of taking a history was completed differently from the method of taking a history that in my day was learnt in hospital, it wasn't learnt in the community, it was learnt in hospital and it was very clinically orientated and the rest of the patient didn't come into it and that wasn't the way I worked.<sup>99</sup>

Each of these three GPs in the quotes above talks of general practice as involving social relationships with patients and/or dealing with wider concerns beyond simply the disease entity. In contrast, they present hospital medicine as lacking these qualities. Moreover, all these quotes draw upon the rhetoric of the whole person and, significantly for the analysis developed here, each employs a mix of these contrasting rhetorical frameworks to produce a border between general practice and the hospital - a border which relates closely to their explanations of unconventional therapies.<sup>100</sup> Here we have clear evidence of how unconventional therapies can act as one particular resource with which to perpetuate the GP/hospital boundary.

### 6.5.2 Hospital as Too Scientific and Academic

The hospital's more towards science in many ways. I mean certainly the cardiologists and things if they speak to us at meetings and things they get very excited about these new drugs and how they interact in this particular receptor and we just sit there and think yeah that's all very nice but basically if Joe Bloggs comes into my surgery with swelling of his ankles and a bad chest I want to know what I can give him and really, and whether he'll tolerate the medication, and while they comply with taking their medication you know does it have side-effects whereby there's not a hope in hell they're going to be taking it. So when they come back next week and they still have their swollen ankles why? Is it really the drugs or is it everything else, is life too busy for them to take their drugs, are the side-effects too bad, do they want to keep on having swollen ankles, what's the agenda here, so that sort of thing. So that's why I see myself as much more, and I'm much more interested in that at this stage in my career than I am in to which particular receptor that this particular new drug works on.<sup>101</sup>

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<sup>99</sup> Dr 10.

<sup>100</sup> Dr 18 provides a similar description of general practice, hospital medicine and the appropriate location of his acupuncture, 'You have a continuing relationship in general practice. You know you see people right through from cradle to grave and in a way that hospital physicians won't. If I'm using acupuncture on a terminally ill case at home then I'll be going in daily [and] you've dealt with that patient for five, ten, fifteen years or longer. There's already that established relationship'.

<sup>101</sup> Dr 11. Similar interpretative repertoires are drawn upon by some GPs in their attack upon evidence-based medicine. This theme is explored more fully in chapter seven.

I enjoy the contact with patients. I thought I wanted to do hospital medicine. I did paediatrics and I looked at the consultant paediatricians and thought really I don't want to end up like that.

Interviewer: Why? How had they ended up?

Unsympathetic...very in an ivory tower and a bit detached from reality.<sup>102</sup>

As we have seen in the last section many of the GPs describe hospital medicine as detached from the patient in terms of ignoring the person and concentrating on the disease. Linked to these devices some doctors describe hospital medicine more specifically as academically-orientated and too scientific, in contrast to their own which is described as 'on the coalface' or 'in the field'.<sup>103</sup> For example Dr 20 explains:

you're not just you know seeing a physical diagnosis and that's the end of it, they are actually people. You know the worst scenario is, and we all did it when we were in medicine, you know over coffee and saying oh I saw you know three cases of rheumatoid arthritis today and the answer is you didn't. You saw three people who had rheumatoid arthritis and you know it's getting out of that really and I think as you come up through hospital medicine it's quite academically-orientated and you tend to be very taken up with the disease and that's healthy in some ways 'cause you're learning but in fact I think more as you go up through general practice you're actually dealing with people who've got the disease which is a different slant on it altogether.<sup>104</sup>

Dr 1 also makes a distinction between the two styles of medicine with reference to his medical training. He says, 'I think while I was doing my training gradually I came to think that what I wanted to do was general practice rather than any hospital specialty which certainly the clinical ones tend to be more scientifically-based'.<sup>105</sup>

Dr 2 provides a similar description of hospital medicine:

What I've noticed is over the years, because I've been qualified quite a long time, you got letters from the hospital and they made some, in the letter they

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<sup>102</sup> Dr 6.

<sup>103</sup> Dr 7 and Dr 3 respectively.

<sup>104</sup> Dr 20.

<sup>105</sup> Dr 1.

always said this dear old lady or this rather abrupt gent or this; they made a comment on the patient's approach, they did an examination, then they did some tests and they gave you an opinion. Now they make no comment about the patient whatsoever - whether she's a dear old lady or a bitch - they make no comments at all. They'll give you a history, they'll give you an examination and they'll give you the results and they'll give you a diagnosis, but there's not an impression or much of a prognosis or much of an opinion as to how this is going to work out. In other words, these guys are relying on their scientist, on their scientific knowledge but their not relying on they're empathetic knowledge of the patient and I feel that's gone far too far the other way.<sup>106</sup>

The use of these rhetorical frameworks to present hospital medicine contrasts to those employed elsewhere by the GPs to describe both their particular complementary practice and their general practice more widely. First, their descriptions of general practice and complementary therapies as intuitive, idiosyncratic and artistic<sup>107</sup> go some way toward contrasting the two styles of medicine. Second the GPs' descriptions of general practice as a flexible and pragmatic style of medicine (and the integration of unconventional therapies as providing supporting evidence for this claim) further distinguishes general medical practice from the descriptions of hospital medicine displayed in the above quotes.

### 6.5.3 Personality Types and the Competitiveness of Hospital Medicine

I am meant to be a GP. I just think, can I blow my own trumpet here?

Interviewer: Sure.

I just think I'm quite a nice person. I'm quite an approachable person. I'm quite a gentle person. I'm not high flying I'm not although I thought I would like the glamour of a hospital specialism, it's a bit more cut throat. There are people stabbing you in the back a bit more for promotion. I think you've got to be tough and I'm not necessarily like that.<sup>108</sup>

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<sup>106</sup> Dr 2.

<sup>107</sup> See section 2.1 in this chapter.

<sup>108</sup> Dr 11. Dr 7 illustrates a similar point when he says, 'essentially I didn't like brown nosing in hospital and I think that's often what you've got to do to get on and I was a mature bloke and I went for jobs in hospitals and thought you know they'd ask what does your daddy do?'

As the quote above suggests some of the GPs portray the hospital as being a competitive environment in which to practise medicine. The talk of Dr 6 exhibits the employment of this same device:

In hospital there were guys who were quite willing to sort of walk all over each other to try and get promoted first and I thought that's just not what I came into medicine for, to, you know, I came in for some other reason not to do this...So, I went into general practice and it was much more my type of medicine where you get to know people and you got to know their families and you got to know the person and you treated them in a different way than you did in hospital.<sup>109</sup>

In stressing the highly competitive nature of hospital medicine in which practitioners focus predominantly on their own careers rather than the patient and in contrasting these traits with those of general practice these GPs reinforce their use of non-contingent and contingent repertoires (the presentation of their own practice as guided by altruism in terms of following patient needs and the presentation of other medical groups' practice being motivated by self interest respectively) as distinguished elsewhere in the analysis of this thesis. It follows that if hospital doctors are portrayed as driven by their own career development then it can be argued that their practice is motivated - partly at least - by considerations other than the interests and needs of the patient.

Often the contrasting imagery used to demarcate the hospital from general practice is integrated with an appeal to the different styles of thought and personality of the groups of doctors in the two settings. Some GPs contrast the hospital doctor - a practitioner with a specialised and narrow focus upon scientific knowledge - with the GP who is not only interested in the scientific elements of medicine but also the wider aspects of life. As one GP explains, 'there's more to life than medicine'.<sup>110</sup> Some

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<sup>109</sup> Dr 6.

<sup>110</sup> Dr 24.

doctors suggest that GPs are more ‘well-rounded’ as people than their hospital counterparts. One doctor describes this difference of interest between hospital specialists and general practitioners in the following way:

There’s the breadth as opposed to the depth of knowledge and to a large extent it’s difficult to generalise with so many people and so many diverse personalities in general practice, but to a larger extent people in general practice have got other interests that aren’t necessarily just golf, you know, you do your work, you have your golf - that’s it! you’re more likely to feel, find GPs with hobbies that range from, you know, the acceptable to the bizarre.

Interviewer: And that brings something to the medicine?

Oh yes it does. I think you bring your whole self, I mean we all bring our baggage to everything.<sup>111</sup>

Many of the GPs describe hospital doctors as intolerant and unfairly critical of complementary therapies. Consultants are presented as narrow-minded and inflexible in response to the growing need for extending the range of treatments beyond simply the conventional, while many of the GPs refer to themselves and their colleagues in general practice as ‘open-minded’ in their attitude to complementary therapies. This focus upon cognitive styles and personalities is once again, in the case of some homeopaths and hypnotherapists, constructed in terms of the right and left brain theory. As one GP characterises the two medical groups, ‘your scientists tend to be left brain and other people who do well with complementary medicine are right brain and they don’t understand each other’.<sup>112</sup> Dr 14 also outlines the difficulties for hospital doctors in taking on board complementary therapies:

we’re generalists and we have an open mind perhaps more. I mean some hospital consultants have an open mind but if you’re very much in a rat race to become a consultant then you’re not going to sit there and talk to your peers that are gonna judge you about homeopathy and hypnosis...so essentially I don’t think that there is room in traditional medicine for these therapies to be

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<sup>111</sup> Dr 10.

<sup>112</sup> Dr 5.



taken on board seriously...I think that you know if you want to be a consultant cardiologist or somebody who's got you know is a specialist in the ear nose and throat, then you really no gonna dabble in these things because that it's difficult to step outside your own comfort zone and say well there's something else here. GPs do it all the time. We don't just deal with medical problems in fact that's the minority of our work up to a point a lot of our work is emotional, it's marriage problems, it's behaviour problems in kids, it's just like I had a patient who came in the surgery one morning and was shaking and bursting in to tears and I think her husband had left her or something and that was in the middle of my surgery now you canna do that in the hospital. They'd say actually madam we're here to talk about your angina, you know the fact of your husband that's very sad but, I just don't think they would spend the time. I mean the patients wouldn't do it either because their perceptions of the hospital is totally different. I think in general practice they look on you sometimes as a friend.<sup>113</sup>

This doctor suggests there are two reasons why complementary medicines are less popular and attract less support from hospital doctors. First, the nature of specialisms - they are a rat race and there is a danger of losing face with peers if doctors promote alternative treatments. Second, the GP draws upon the rhetoric of personal doctoring to contrast the hospital with the general practice surgery. Moreover, the personal style of doctoring which is found in general practice (and which is so compatible with complementary practice) is also seen as absent from hospital medicine, partly because of patient expectations. This rhetorical claim relates back to the notion common in many accounts which suggests that GPs are the doctors *in* the community in terms of patient perceptions.

Once again with the quote above we see the use of contingent and non-contingent interpretative frameworks in order to demarcate general practice from, and also in the process denigrate, the practice of another medical group; the implication

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<sup>113</sup> Dr 14. Dr 11 talks of hospital consultants in much the same terms. She says: 'somebody's come in here and burst in to tears and say my marriage is on the rocks and I don't know what to do they would never walk in to a medical outpatients' department in Edinburgh Royal Infirmary and see the consultant and say you know I know I'm here with a pain in my stomach but basically my marriage is on the rocks, you know, it just doesn't happen. They have this big desk and you know it's between them and I don't



that hospital medicine is not based solely upon patient needs is, as previously discussed in relation to an earlier extract of talk, supported with reference to the 'rat race' amongst consultants. This is a rat race which through the need to save face in the eyes of peers encourages consultants to practice caution when considering whether or not to employ unconventional treatments.

Another GP outlines in rather eloquent terms what he sees as a contrast between the attitudes of general practitioners and hospital doctors towards complementary therapies:

you find some [opposition to complementary therapies] in general practice but general practitioners are generally much more intelligent and open-minded than hospital practitioners who to be fair to them have an interest position to defend. They are supposed to be experts so they can't possibly say that this GP practising voodooism is better at rheumatology than me cause I'm a professor.<sup>114</sup>

This GP, like the one previously quoted, turns to the lack of interest in unconventional therapies amongst hospital practitioners as a means of displaying disparity between the two sets of doctors. Here, however, the talk also more directly attributes professional interests to the behaviour of hospital practitioners; support for the use of contingent and non-contingent repertoires is aided through describing hospital doctors as experts who in defence of their expert status are intolerant of alternative treatments.

Analysis of the quotes in this section reveals how the development of unconventional therapies by general practitioners and the relative lack of interest shown in these treatments amongst specialists is in itself pin-pointed by these GPs as further evidence of the contrasting cognitive styles prevalent within the two medical settings. In this sense, the claim that unconventional therapies are more widely

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think they've yet got used to this kind of, you know, it's the big desk and the white coat that separates you as well in the hospital environment, and it's yes, it's not conducive to people opening up'.

<sup>114</sup> Dr 8.

promoted and accepted in general practice acts as a popular tool for these GPs in their endeavour to promote general practice as distinct from hospital medicine.

## 6.6 Summary and Discussion

As has been shown in this chapter, while different GPs often employ slightly different rhetorical tools in their construction of professional identity and role, it is nonetheless the case that the demarcation from hospital medicine can be identified across all the accounts. Through an appeal to a range of rhetorical devices (in particular the holistic nature of both general practice and complementary therapies) the doctors differentiate their practice and role from those found within the hospital medical paradigm. These presentations can be contextualised within the wider history of the medical profession and the particular history of hospital/GP relations throughout the twentieth-century.

The problematic identity and role of general practice has been elucidated by a number of writers.<sup>115</sup> Throughout its historical development during the late nineteenth-century and the twentieth century, general practice has continually represented a fragile and disputed area of practice within the British medical system. The search for a specific role and identity for this branch of the medical profession has been dogged by uncertainty and ambiguity<sup>116</sup> and as a domain of knowledge general practice has been 'under-structured in epistemological terms'.<sup>117</sup> For the majority of its professional development general practice has been a poor relation to hospital medicine. In response some within general practice have attempted to codify a distinct

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<sup>115</sup> Jefferys, M. and Sachs, H. (1983). *Op. Cit. No. 5*. Bowling, A. (1981). *Op. Cit. No. 37*. Stevens, R. (1966). *Medical Practice in Modern England: The Impact of Specialisation and State Medicine*. London, Yale University Press. Honigsbaum, F. (1979). *The Division in British Medicine*. London, Kogan Page.

<sup>116</sup> Jefferys, M. and Sachs, H. (1983). *Op. Cit. No. 5*.

<sup>117</sup> Osborne, T. (1993). 'Mobilising Psychoanalysis: Michael Balint and the General Practitioner'. *Social Studies of Science* 23: 175-200.

set of practice skills and approaches distinct from the increasingly reductionist gaze of hospital medicine.<sup>118</sup>

Such developments have resulted in a significant and far-reaching division within British medicine: the divide between specialist, hospital-based medicine and the work of general practitioners. Effectively, the hospital-based consultants found themselves at the forefront of scientific medical endeavours.<sup>119</sup> Meanwhile, the general practitioner evolved as essentially the 'gatekeeper' to such specialised services. As a result a growing number of general practitioners came to perceive their ordained role in terms of frustration and dissatisfaction, directing what they considered to be the interesting and medically challenging cases to their hospital colleagues.<sup>120</sup>

The intra-professional rivalry between hospital-based specialists and general medical practitioners has produced repeated attempts from within general practice to improve and clearly demarcate the status, practice and location of this branch of medicine within the wider medical system. As Calnan and Gabe state, 'the control that hospital doctors gained over the medical marketplace in the nineteenth-century and early twentieth-century set the agenda for future debate about the role of general practitioners and the identification of the most effective strategy for enhancing

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<sup>118</sup> This situation has its origins in the old tripartite system of medicine prior to 1858. Moreover, both the National Insurance Act of 1911 and the introduction of the National Health Service in 1948 further encouraged the disparity between general practitioners and their hospital cousins. Regarding National Insurance and its affect upon the GP/hospital divide see: Porter, R. (1997). *The Greatest Benefit to Mankind*. London, Harper Collins. p.639. With relation to the National Health Service Act and subsequent GP contracts and status: Stevens, R. (1966). *op cit*. p77. Armstrong, D. (1979). *Op. Cit. No. 49*.

<sup>119</sup> Armstrong, D. (1979). *Ibid.* has highlighted this point. He writes, 'true, the GP was employed in the examination and investigation of individual bodies but the hospital setting, with its accompanying resources, produced a more efficient and powerful gaze'. p.74.

<sup>120</sup> This point is illustrated by Armstrong with reference to the tendency of general practitioners to define patients and tasks in terms of trivia. He suggests, 'the concept of the trivial patient first achieved wide discussion in the early years of the NHS. But though trivia were seen as an inevitable problem of general practice they were the product of the hospital ideology'. Armstrong, D. (1979) *Ibid.* p.4.

professional development'.<sup>121</sup> Indeed, the dominance of the hospital paradigm with its emphasis upon pathology and specific disease entities has been instrumental in shaping the perceptions and claims of many within general practice regarding their identity and role. Shortly after the creation of the NHS in 1948 and up until the early 1960s general practice was seen by some within or associated with the profession as in a state of 'crisis'.<sup>122</sup> Morale was seen as at an all-time low and the popular suggestion that general practitioners represented little more than 'failed consultants' appeared ever more real.<sup>123</sup> It was perceived by many that the gap between hospital medicine and general practice had become too wide and there were calls for a closer co-operation between the two sectors. Much of the professional strategy at this time clearly reflects the strangle-hold that the medical ideology of the hospitals had over the agenda of general practice. Writers and practitioners suggested that GPs should develop minor surgery in their practices, should be assigned a number of beds in local hospitals and should be encouraged to actively participate in hospital practice on a part-time basis.<sup>124</sup> All these suggestions effectively construct general practice in terms of the dominant hospital cosmology; if general practice was a low status profession, the solution, as constructed by these writers and medics, would be for GPs to enter or

<sup>121</sup> Calnan, M. and Gabe, J. (1988). 'Recent Developments in General Practice: A Sociological Analysis'. In J. Gabe, M. Calnan and M. Bury (eds). *The Sociology of the Health Service*. London, Routledge.

<sup>122</sup> Hart, J. T. (1992). 'The British Medical Journal, General Practitioners and the State, 1840-1990'. In W. F. Bynum, S. Lock, and R. Porter, (eds). *Medical Journals and Medical Knowledge: Historical Essays*. London, Routledge. Bryden, P. (1992). 'The Future of Primary Care'. In R. Loveridge and K. Starkey (eds). *Continuity and Crisis in the NHS*. Buckingham, Open University Press.

<sup>123</sup> Some commentators and writers even suggested the death of general practice. They claimed that general practice would be subsumed within hospital medicine or become little more than a screening service for patients before they received treatment in hospital.

<sup>124</sup> See Brown, J. S. (1979). 'Minor Operations in General Practice'. *British Medical Journal* 1: 1609-1610. Gerard, E. (1993). 'GP Minor Surgery'. *Doctor* 11th March: 45. Kneebone, R. L. (1994). 'Training General Practitioners in Minor Surgery'. *British Journal of General Practice* 44: 103-104. Morrison, J. M. and Murray, T. S. (1993). 'Survey of Minor Surgery in General Practice in the West of Scotland'. *British Journal of Surgery* 80: 202-204. Leese, B., Taylor, C. and Bosanquet, N. (1995). *A Stitch in Time? Minor Surgery in General Practice*. Discussion Paper 12, York, University of York. Wall, D. (1991). 'Minor Surgery in General Practice'. *Primary Health Care Management* 1(10): 10-11.

at least experience some of the action within the more glamorous and interesting arena of hospital medical practice.<sup>125</sup>

However, alternative claims and suggestions from within general practice can also be identified. Some within general practice visualised the advancement of their branch of medicine and its professional development in quite different terms. They wished to carve out a place and identity for general practice which did not seek to emulate the hospital paradigm, but instead defined general practice in terms distinct from those found within hospital medicine; it was general practice itself that needed developing rather than any relations with hospital medicine. On a formal level these endeavours found an outlet in organisational changes, with a section of general practice being formed at the Royal Society of Medicine in 1950, and with the founding of the Royal College of General Practice three years later.<sup>126</sup> The College's aim was to enhance the standing of general practice and to promote further professional development,<sup>127</sup> and it was instrumental in campaigning for the GP charter of 1965 which addressed poor remuneration and working conditions in general practice.

Despite the fact that general practice has made ground over recent years especially with the movement towards a primary care-led NHS,<sup>128</sup> evidence suggests that general practitioners are still the poor relations of hospital specialists at least in

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<sup>125</sup> See Armstrong, D. (1979). *Op. Cit. No. 49*.

<sup>126</sup> For an interesting examination of the attempt to establish a College of General Practice dating back to 1812 see Loudon, I. (1988). *Op. Cit. No. 25*.

<sup>127</sup> See Reid, M. E. (1980). *The Development of Academic General Practice in Scotland: A Sociological Analysis*. Unpublished Ph.D. Thesis, University of Glasgow. This mission - one of reconceptualising the GP's role and practice - is not surprising given that, as Armstrong identifies, 'the College...was the immediate outcome of an occupational group thrown together for the first time in their history through the total triumph of hospital medicine'. Armstrong, D. (1979). *Op. Cit. No. 49*. p5.

<sup>128</sup> See Meads, G. (ed.) (1996). *A Primary Care-Led NHS*. Edinburgh, Churchill Livingstone. For wider examination of the recent developments regarding general practice see Elston, M. A. (1991). 'The Politics of Professional Power'. In J. Gabe, M. Calnan and M. Bury (eds). *The Sociology of the Health Service*. London, Routledge. Calnan, M. and Gabe, J. (1991). *Op. Cit. No. 121*.

terms of the perceptions of other sections of the medical community.<sup>129</sup> Furthermore, as the present study helps illustrate, GPs themselves continue to distance themselves from the hospital setting and specialist medicine.<sup>130</sup>

There have been specific developments within general practice relating to certain clinical practices and recommendations that can be seen as attempts to establish a distinct identity for general practice and thereby draw the profession away from the shadows of hospital medicine. For example some within general practice have put forward a rhetoric of prevention,<sup>131</sup> while others have proposed an interest in psychoanalysis under the influence of Balint's writings<sup>132</sup> or for the development of counselling as a central component within general practice.<sup>133</sup> All these rhetorics help present general practice in holistic terms; they all call for an extension of the biomedical model to include wider considerations beyond purely the analysis of physical symptoms, and they can all be seen as attempts from within general practice to further consolidate a professional identity which is distinct from hospital medicine.<sup>134</sup>

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<sup>129</sup> Furnham, A. F. (1986). 'Medical Students' Beliefs about Nine Different Specialties'. *British Medical Journal* 293: 20-27.

<sup>130</sup> For an example of such distancing from within general practice see Marinker, M. (1994). *The End of General Practice*. The 1994 Bayliss Lecture, BMJ.

<sup>131</sup> For examination of prevention rhetoric as it applies to general practice see Williams, A. and Boulton, M. (1988). 'Thinking Prevention: Concepts and Constructs in General Practice'. In M. Lock and D. Gordon (eds). *Biomedicine Examined*. London, Kluwer Academic. Davies, C. (1984). 'General Practitioners and the Pull of Prevention'. *Sociology of Health and Illness*. 6(3): 267-289.

<sup>132</sup> Osborne, T. (1993). *Op. Cit. No. 117*. Armstrong, D. (1979). *Op. Cit. No. 49*. For details of Balint's writing see Balint, M. (1957). *The Doctor, The Patient and His Illness*. London, Pitman.

<sup>133</sup> Keithley, J. and Marsh, G. (eds) (1995). *Counselling in Primary Healthcare*. Oxford, Oxford University Press. While some have written of introducing counsellors alongside general practitioners (see East, P. (1995). *Counselling in Medical Settings*. Buckingham, Open University Press) others have explored the potential counselling role of the GP him or herself see Camplin, M. (1995). 'The GP as Counsellor'. In J. Keithley and G. Marsh (eds). *Counselling in Primary Healthcare*. Oxford, Oxford University Press.

<sup>134</sup> For an interesting discussion of this point see, Honigsbaum, F. (1985). 'Reconstruction of General Practice: Failure or Reform'. *British Medical Journal* 290: 823-826. Honigsbaum links these expansions of general practice into different areas of practice with the programme of the Royal College of General Practitioners (RCGP). He writes of the RCGP: 'they seem to fear most any move that will carry general practitioners closer to hospital medicine, so much so that it might be fair to describe their proposals as the "keep general practitioners busy in the community" school. For them, almost any



Complementary therapies as described and presented by the GPs in this study provide yet another set of rhetorical resources by which general practice is promoted as holistic and this branch of medicine situated within the community. Moreover, the explanations of these therapies also enable the GPs to further develop their professional identity as distinct from the hospital paradigm. Effectively, this is achieved through the presentation of complementary therapies as maintaining and enhancing a holistic clinical approach within general practice - an approach which, it is claimed, is absent from hospital medicine. Seen in these terms we can appreciate the far-reaching opportunities that complementary therapies bring to this group of general practitioners in their ongoing struggles within the medical division of labour.

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activity will do as long as it leaves general practitioners free from entanglement with consultants. This apparently includes even the arcane therapies of alternative medicine'. p.826.

## **Chapter Seven**

### **Intra-Professional Strategy: The Role of Unconventional Therapies in the Defence of Clinical Autonomy**

## 7.1 Introduction

The topic of evidence-based medicine (EBM) is raised by a number of doctors in their accounts. More particularly, EBM is explained by the GPs as a threat to their current approach to clinical practice and, consequently, EBM is understood to be in tension with both the development of unconventional therapies within their surgeries and authentic primary care more generally.

As already explained in the last chapter, many of the GPs draw upon the rhetorics of intuition, artistic practice and medical holism when describing their professional identity and role. These rhetorical devices enable the GPs to not only present their medical practice as distinct from hospital medicine but also to justify and explain their development of unconventional therapies within the setting of general practice. In addition, these three particular repertoires are also employed by some GPs to perform another quite separate ideological task. In the sense of being described, at least in part, in terms of these specific rhetorics unconventional therapies represent a powerful resource with which some of these GPs defend their clinical autonomy and freedom from what they perceive to be the threat of EBM. It is to these critical descriptions of EBM and the related explanations of unconventional medicines that this chapter now turns attention.

## 7.2 The Rise of Evidence Based Medicine

The temptation to reject (Evidence Based Medicine) as ‘cook-book medicine’ can be strong among those who feel that their professional competence is being questioned and their clinical freedom threatened by people who are frequently no longer in regular contact with patients. However much the EBM community may stress the fact that traditional skills and practices remain a key part of professional competence, there will be those who feel that the venerable art of medicine is being unfairly devalued by people who are not practising it on a day-to-day basis. Diagnosis by scientific literature, they feel, is the antithesis of what medicine should be about. It ignores the uncertainty inherent in much of medical practice, and arbitrarily excludes the knowledge and understanding that can be provided by what have been called the ‘non-biological arts’. Not all that is measurable is of value, and not all that is of value can be measured, according to this view.<sup>1</sup>

The debate continues as to whether all round clinical experience can be dissected down to a set of objective and measurable components that are amenable to formal performance review or whether it is ultimately subjective and one of the unsolvable mysteries of the art of medicine.<sup>2</sup>

Evidence-based medicine - ‘the process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions’<sup>3</sup> - has become a central topic of medical debate over recent years.<sup>4</sup> Prestigious medical journals have dedicated countless articles and papers to the topic, a new journal committed entirely to the approach was launched in 1995<sup>5</sup> and a number of EBM units or academic centres have developed around the country with a view to assessing and promoting EBM across the spectrum of medical sub-specialties.<sup>6</sup> Moreover, while the evidence based approach was initially targeted at the secondary care sector some

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<sup>1</sup> Grayson, L. (1997). *Evidence-Based Medicine*. London, British Library.

<sup>2</sup> Greenhalgh, T. (1995). ‘Is My Practice Evidence-Based?’. *British Medical Journal* 313: 958.

<sup>3</sup> Rosenberg, W. and Donald, A. (1995). ‘Evidence-Based Medicine: An Approach to Clinical Problem Solving’. *British Medical Journal* 310: 1122-6.

<sup>4</sup> Grayson, L. (1997). *Op. Cit. No. 1*. p4. Rees, J. (1995). ‘Where Medical Science and Human Behaviour Meet’. *British Medical Journal* 310: 850-3. Walshe, K. and Ham, C. (1997). ‘Who’s Acting on the Evidence?’. *Health Service Journal* 107(5547): 22-25. (Anon.) (1996) ‘Evidence-Based Medicine’. *British Medical Journal* 313: 169-171.

<sup>5</sup> The Journal, entitled *Evidence Based Medicine*, is a joint venture between the American College of Physicians and the British Medical Association. David Sackett has been instrumental in founding this publication and is editor at the time of writing.

<sup>6</sup> For example ‘The Centre for Evidence-Based Medicine’ was established at Oxford University in 1993.

within primary care have shown a keenness to promote and apply the basic principles of EBM to the general practice environment.<sup>7</sup>

The first significant proponent of what has become known as EBM was Cochrane, who, back in the early 1970s, outlined a primary role for randomised controlled trials in dictating clinical practice.<sup>8</sup> Since these first tentative suggestions the banner of EBM has more recently been hoisted by a new generation of figures from within the medical profession. Amongst these more contemporary supporters David Sackett has effectively been cast by many as the leading spokesperson at the head of the movement.

As writers have often observed, doctors and many of those outside medicine may perceive the movement of EBM as a 'clear non-starter'.<sup>9</sup> Such critics have questioned the relevance of this 'new' approach and suggest that EBM is simply a new name for what medical practitioners have been doing for some time.<sup>10</sup> Indeed, the rhetoric of science has been at the foundation of the medical profession's cultural authority in defining medical problems and effective clinical practice.<sup>11</sup> However, at the heart of EBM we can detect a premise that questions the commonly held view of medical practice as based upon a bedrock of scientific evidence.

There has been much debate as to the extent to which scientific evidence informs contemporary clinical practice. Conflicting findings have ranged from claims

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<sup>7</sup> Dawes, M. G. (1996). 'The Need for Evidence-Based General and Family Practice'. *Evidence-Based Medicine* 1(3): 68-69. Gill, P. *et al.* (1996). 'Evidence-Based General Practice: A Retrospective Study of Interventions in One Training Practice'. *British Medical Journal* 312: 812-21. Ridsdale, L. (1995). *Evidence-Based General Practice: A Critical Reader*. London, British Medical Journal. Lipman, T. *et al.* (1997). 'Evidence-Based Medicine in Primary Care: Some Views From the 3rd UK Workshop on Teaching Evidence-Based Medicine'. *Evidence-Based Medicine*. (2)2 : 133-135.

<sup>8</sup> Cochrane, A. (1972). *Effectiveness and Efficiency. Random Reflections on Health Services*. London, Nuffield Provincial Hospital Trust.

<sup>9</sup> Grayson, L. (1997). *Op. Cit. No. 1*. p.7

<sup>10</sup> Haynes, R. B. (1993). 'Where's the Meat in the Journals'. *ACP Journal Club* 119(4): 23-4

that up to 80% of medical practice is evidence based<sup>12</sup> to reports that as little as 15% of current medical treatments are informed by reliable scientific research.<sup>13</sup> Moreover, supporters of EBM have justified the approach through the claim that much of the current day-to-day work of the individual practitioner is conducted *in spite of* scientific evidence and as Davidoff *et al.* suggest 'there is a widening chasm between what [practitioners] ought to do and what [practitioners] actually do'.<sup>14</sup> Often, it is argued, practitioners simply ignore or reject research findings, are poorly informed of the latest results of clinical trials or alternatively feel overwhelmed by the increasing flow of research papers published in the growing number of medical journals available.<sup>15</sup>

Clinical autonomy provides an important basis to the authority of individual practitioners.<sup>16</sup> This autonomy has often been justified by these practitioners in terms of clinical expertise and until recently this aspect of their clinical work has passed largely unchallenged and has escaped systematic surveillance.<sup>17</sup> Allsop argues: 'there (has been) virtually no knowledge about, or scrutiny of, the day-to-day work of general practitioners apart from some monitoring of prescribing from peers and

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<sup>11</sup> Allsop, J. (1995). 'Shifting Spheres of Opportunity: The Professional Powers of General Practitioners Within the British National Health Service'. In T. Johnson, G. Larkin, and M. Saks (eds). *Health Professions and the State in Europe*. London, Routledge.

<sup>12</sup> Ellis, J. *et al.* (1995). 'Inpatient General Medicine is Evidence-Based'. *Lancet* 346(8979): 407-410

<sup>13</sup> Gill, P. *et al.* (1996) *Op. Cit.* No. 7. Smith, R. (1991). 'Where is the Wisdom...? The Poverty of Medical Evidence'. *British Medical Journal* 303: 798-9

<sup>14</sup> Davidoff, F. *et al.* (1995). 'Evidence-Based Medicine. A New Journal to Help Doctors Identify the Information They Need'. *British Medical Journal* 310: 1085-6

<sup>15</sup> Some writers have calculated that a doctor would have to read up to 9 original research papers a day to keep a breast of developments in their field alone. Davidoff, F. *et al.* (1995) *Ibid.*

<sup>16</sup> Gordon, D. (1988). 'Clinical Science and Clinical Expertise: Changing Boundaries Between Art and Science in Medicine'. In M. Lock and R. Gordon (eds). *Biomedicine Examined*. London, Kluwer Academic. Porter, R. and Bynum, W. F. (1993). 'The Art and Science of Medicine'. In W. F. Bynum and R. Porter (eds). *Companion Encyclopaedia of the History of Medicine*. vol. 1. London, Routledge.

<sup>17</sup> Freidson, E. (1970). *Profession of Medicine*. New York, Doubleday and Mead. Pelligrino, E. D. (1979). 'Medicine, Science, Art: An Old Controversy Revisited'. *Man and Medicine* 4: 43-52.

others'.<sup>18</sup> However, the health reforms of the last two decades which have transformed the purchasing and provision of care on the National Health Service have had a major impact on this element of professional power.<sup>19</sup> The introduction of market forces and the increasing interest of recent Governments in the organisational change and cost control of primary care services<sup>20</sup> have represented significant challenges to the authority and power of practitioners with regard to their clinical decision-making.<sup>21</sup>

Linked to the issue of cost containment, some commentators have conceptualised EBM as a vehicle with which health authorities and other NHS purchasers have attempted to justify a more focused rationing of medical provision<sup>22</sup> and leading writers from within the EBM movement have often been at pains to distance themselves from this concern with restricting health care resources.<sup>23</sup> One of the doctors in the study outlines a concern with these issues in his talk. He too, constructs EBM, amidst other recent developments facing general practice, as a tool for rationing within the National Health Service. He states, 'managerialism, auditing, cost effectiveness, the clinical effectiveness, evidence-based medicine, all these words, all these concepts, the purchasing, it's all ultimately rationing'.<sup>24</sup> However, the threat of EBM is not, in the main, explained by these GPs in terms of rationing.

<sup>18</sup> Allsop, J. (1995). *Op. Cit. No. 11*. p.77. Berg also supports this claim. He states with reference to the inter war years, 'the performance of the physician's job itself, the artful application of scientific knowledge to unique individuals, was not called into question'. Berg, M. (1995). 'Turning a Practice into a Clinical Science: Reconceptualising Post-war Medical Practice'. *Social Studies of Science* 25: 437-476. p.438.

<sup>19</sup> Allsop, J. (1995). *Op. Cit. No. 11*. p.76.

<sup>20</sup> Meads, G. (1996). *A Primary Care-Led NHS*. London, Churchill Livingstone.

<sup>21</sup> Gordon, D. (1988) *Op. Cit. No. 16*. p.262. Gordon, P. (1995). 'Core Values', *Health Service Journal*. 105(5452) : 24-25.

<sup>22</sup> Hunter, D. G. (1996). 'Rationing and Evidence-Based Medicine'. *Journal of Evaluation of Clinical Practice* 2(1): 5-8

<sup>23</sup> Milne, R. and Hicks, N. (1996). 'Evidence-Based Purchasing'. *Evidence-Based Medicine* 1(4): 101-2. As Grayson states, 'evidence-based medicine as a purely professional response to the desire to improve the quality of care for individual patients has been seized upon (some say hijacked) by health service policy makers and managers in pursuit of a more efficient health service'. Grayson, L. (1977). *Op. Cit. No. 1*. p.xiii.

<sup>24</sup> Dr 1.



Instead, they are keen to present EBM as representing a more direct threat to their clinical expertise (as described in terms of intuition and the art of medicine).

EBM can be contextualised within a wider movement within medicine which has sought to develop clinical practice as a clinical science and to thereby expose clinical decision-making to more precise, explicit, analytical and quantified assessment.<sup>25</sup> As Gordon writes with reference to these developments in medicine: ‘intuition is currently being challenged within the medical profession, with some demanding that it should be replaced by explicit, rational calculation’.<sup>26</sup> Furthermore, proponents of EBM have portrayed the approach as the possible saviour of medical practice which is currently seen as the victim of much uncoordinated, ill-informed and ineffective decision-making. As Smith attests, ‘the weakness of the scientific evidence underlying medical practice is one of the causes of the wider variations that are well recognised in medical practice’.<sup>27</sup> Indeed, many supporters of the EBM approach claim a need to *standardise* treatments as a means of dictating more effective clinical practice and with reference to this theme claim that EBM ‘seems to be able to halt the progressive deterioration in clinical performance’ amongst doctors.<sup>28</sup>

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<sup>25</sup> Gordon, D. (1988). *Op. Cit. No. 16*. Berg, M. (1995). *Op. Cit. No. 18*.

<sup>26</sup> Gordon, D. (1988). *Ibid.* p.258.

### 7.3 GPs, Unconventional Therapies and EBM

The increasing interest in EBM has not passed without some harsh criticism. The topic remains controversial within medical circles with both the medical elite<sup>29</sup> and grass-roots practitioners raising objections and concerns about the approach.<sup>30</sup> Likewise, some of the GPs in this study portray EBM as signifying a movement of thought that is restrictive and, furthermore, fundamentally opposed to the necessity for clinical freedom - a freedom which, notably, includes the choice to practise complementary therapies where deemed appropriate. This objection to EBM can be seen in the following extract from the talk of Dr 15:

Evidence based medicine and me are in a pickle. I don't believe in it. I find it incredibly threatening to the way I conduct my business of being a GP because I don't conduct it in that way. I might treat your asthma totally differently from that asthma, the same way as I'd do if I was treating it homeopathically, you know, that you over there and Gene over here aged seventy-nine highly unlikely to get the same thing. I also like to feel that's possible to do that with allopractic medicine and guidelines and evidence based medicine and the rest of it, they make a mockery of the individual relationship with people being important and I think basically they are setting up to do away with general practice and I think they, if one extrapolates from where we are just now all of those things can be done with a performer and a protocol and you don't need a doctor. So I think we are seeing gradually the demise of general practice and I think we are seeing the demise of pastoral care, it's gone from the church and I think it's going from general practice with this what is thought to be science and evidence-based.<sup>31</sup>

Dr 19 also explains how EBM signifies a push or movement in opposition to his use of acupuncture:

you see there's the whole other push of evidence based medicine, that doctors should only do things where there's a research, where the research has proven it works and you know you will not give a drug unless research has shown that that drug works for that illness and acupuncture's the same, you know a lot of

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<sup>27</sup> Smith, R. (1991). *Op. Cit. No. 13*. p.798.

<sup>28</sup> Davidoff *et al.* (1995). *Op. Cit. No. 14*. p.1085.

<sup>29</sup> Editorial (1995). 'Evidence-Based Medicine, in its Place'. *Lancet* 346(8978): 785

<sup>30</sup> Smith, B. H. (1996). 'Evidence-Based Medicine'. *British Medical Journal* 313: 169. Graham-Smith, D. (1995). 'Evidence-Based Medicine: Socratic Dissent'. *British Medical Journal* 310: 1126-7

<sup>31</sup> Dr 15.

people would say right well you're not allowed to give it because it's not evidence based. A lot of people are trying to restrict it and trying to, trying to, trying to throw out a lot of treatments because they don't work, like you know, well giving some drug for night leg cramps at night and it doesn't work and so therefore why give it. Well that's fair enough but at the same time people are throwing out the baby with the bath water, they're getting, they're throwing everything out because there's no research on it, you know, I'll never do that again because nobody has ever proven it works even though so many people know it does.<sup>32</sup>

One rhetorical device which is commonly employed within the accounts of these GPs (illustrated in the extract from the talk of Dr 15 above) is to stress the notion of individualised treatment and practice. As outlined earlier in chapter six, many of the GPs explain their clinical practice as a response to the complex processes of illness. Illness is conceived of in wider terms than purely physical complaints, and straightforward disease categories are derided as an over-simplistic schema with which to appreciate the multidimensional layers of much illness. Moreover, complementary therapies are constructed by these GPs as aiding this individualised approach to illness - helping provide clinical treatments which are tailored to patients' specific and unique life circumstances rather than to generalisable and standardised categories of illness. This presentation of unconventional therapies is illuminated in the quote above (#32 of Dr 15) where he explicitly links individualised treatment to his use of homeopathic remedies.

Not surprisingly, related to this notion of individualised treatments and practice is a stress upon the significance of the individual patient as an object of medical attention. There is a portrayal within some accounts of an evidence-based approach ignoring the individual patient and as Dr 15 affirms: 'I can't see the patient

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<sup>32</sup> Dr 19.

very strongly in the evidence based model'.<sup>33</sup> One GP draws upon the theme of randomised controlled trials as a means of illustrating this point. She says:

Its a fact that no matter, your gold standard randomised controlled trial is about thirty patients that get this and thirty patients that get that and then you generalise the experience of the thirty and you generalise the experience of the other thirty and its actually about nobody's experience, its not about one individual's experience. The problem is the idea and philosophy behind randomising people is so alien to what my central opinion is as to what you do when a patient comes to seek help in front of you

Interviewer: So is something missing? Why is evidence based medicine so alien to your idea of practice?

Because you've got the art of individual, its the individual.<sup>34</sup>

This extract reveals how the rhetoric of artistic practice is employed by this GP to criticise EBM and to distance her practice from the evidence-based approach. Here there is a suggestion that the use of scientific trials to assess the efficacy of treatments is misguidedly geared towards the general rather than the local through an insistence that evidence be reproducible.<sup>35</sup> This claim augments the GPs' presentation of EBM as a standardising and thereby restrictive regime of medical thought.

This GP also later explains how the general practice consultation itself can be seen as revealing the 'truth about an individual'. Here, as with the boundary work relating to hospital medicine, the general practitioner is portrayed as the doctor of the individual patient. She goes on to say:

We're actually doing NF1 trials all the time in general practice and that gives you the truth about an individual and then what you could do I suppose is add

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<sup>33</sup> Dr 15.

<sup>34</sup> Dr 25.

<sup>35</sup> A stress upon treating the individual patient as opposed to wider populations has been emphasised by some writers from within primary care. Some claim that the values of practitioners are often in conflict to the values of their wider practice and that the traditional emphasis on the health of the individual patient may be currently under threat. For example, see Gordon, P. (1995) *Op. Cit. No. 21*. And Pratt, J. (1995). *Practitioners and Practices: A Conflict of Values?* Oxford, Radcliffe Medical Press. A similar theme drawing upon similar rhetorics is employed by these GPs; they present EBM as eroding an approach which recognises the 'whole' patient and treats the patient as an individual - features which are held to be amongst the core values of general practice.

all that up to get a truth about thirty individuals whereas all this evidence based is constructed on averaging of no individuals, they don't exist.<sup>36</sup>

As will be seen later in this section, these descriptions run alongside another set of rhetorics whereby some GPs position EBM as opposed to holistic medical practice and whereby they also attempt to deauthenticate the evidence-based approach as unrealistic and divorced from the realities of everyday clinical work in the surgery.

EBM is presented by some of these GPs as an extreme scientific approach to clinical practice which neglects the importance of the practitioner and actually brands him or her irrelevant and therefore redundant with regard to effective general practice. EBM, it is argued, not only overlooks the importance of the patient in clinical practice but also the significance of the whole human dimension as encapsulated in the doctor-patient relationship and communication in the consultation. As Dr 15 suggests of EBM and its supporters in quote #31 outlined earlier, 'they make a mockery of the individual relationship with people being important' and 'if one extrapolates from where we are just now all of those things can be done with a performer and a protocol and you don't need a doctor'.<sup>37</sup> Likewise, some commentators have identified the increasing movement towards developing clinical practice as a science as asserting that 'the art of medicine is something that computers can or will be able to do'.<sup>38</sup> A number of GPs are keen to stress what they see as their essential role in both diagnosis and treatment. There is a play upon the imagery of high-technology and overly scientifically-based practice as being detached from patient-centred care, again these presentations are mirrored in more formal attacks upon EBM as found within the

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<sup>36</sup> Dr 25.

<sup>37</sup> Dr 15.

<sup>38</sup> Gordon, D. (1988). *Op. Cit. No. 16*. p.217.

medical press<sup>39</sup> with some writers stressing the importance of acknowledging the patient's perspective when assessing medical practice.<sup>40</sup> Dr 21 outlines how she sees the GP as more than simply the equivalent of a machine or computer and how her role is patient-centred. She says:

There's not a computer or an [.....] in here that says, you know, list your symptoms therefore the diagnosis is, therefore the treatment is such and such. There's someone showing an interest and, you know, I think it's, caring is the word, that there's somebody showing an interest, taking the trouble to try and find out what is wrong, what is the best way to treat you and cares whether you get better or not.<sup>41</sup>

Another doctor also explains the need for the human element in medical practice. In this case he links this perception more directly to the multidimensional and complex processes of clinical practice and decision-making. He states:

when you factor in all the individual variances from person to person, patient to patient, it'll become far more complex than the biggest computer in the world could handle. It's humanitarian or a humanistic type of job, a humanistic type of role that we fulfil.<sup>42</sup>

Some critics of EBM writing in medical journals have employed similar discursive constructions as a means of attacking the approach. For example, Rees, who scathingly defines EBM as medicine by numbers, claims the approach develops practitioners into 'a set of logical programs designed by health planners'.<sup>43</sup> As he explains his objection to EBM in his writing:

it is fashionable to imagine that most of medicine can somehow be reduced to a set of axioms, checklists and algorithms: medicine by numbers. And in this analogy we can include not just medical 'facts' but somehow all the humans as well - [doctors] are just commodities after all. In this model, medicine - people

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<sup>39</sup> One example of such formal criticism is Greenhalgh, T. (1995). *Op. Cit. No. 2*. who suggests that one difficulty facing EBM is the 'degree of patient-centredness of a medical decision'. p.958.

<sup>40</sup> Carr-Hill R. (1995). 'Welcome? To The Brave New World of Evidence Based Medicine'. *Social Science and Medicine* 41(11): 1467-1468. Naylor, C. D. (1995). 'Grey Zones of Clinical Practice: some Limits to Evidence Based Medicine'. *Lancet* 345: 840-842.

<sup>41</sup> Dr 21.

<sup>42</sup> Dr 1.

<sup>43</sup> Rees, J. (1995). 'Where Medical Science Meets Human Behaviour'. *British Medical Journal* 310: 850-853. p.850.



and all - is just a sort of giant Victorian clockwork mechanism, but with flow diagrams instead of levers.<sup>44</sup>

All the GPs' talk presented so far in this chapter describes EBM as in outright opposition and detrimental to their style of clinical practice and, moreover, as in opposition to their development of complementary therapies. However, other GPs' accounts reveal a construction of EBM in less critical and oppositional terms. These doctors do not explain an evidence-based approach as fundamentally opposed or as an irrelevance to their clinical work, but instead, while accepting the approach has a role to play in directing their decision-making, claim that it should be considered alongside the insights gained from clinical experience. There is a talk of a need for 'a combination of both of the attitudes' of 'science' (as represented by EBM) and 'art' (as represented in terms of the artistic skills and the tacit and intuitive knowledge of the practitioner).<sup>45</sup> The combination of these two rhetorics - science and art - and their association with evidence-based medicine and complementary therapy respectively, is illuminated in the following quote from the talk of Dr 24. He says:

I think [general practice] is the art of applying science. I think science is important for some things. I think, for example, if you've made a diagnosis of angina the science would come into saying nowadays what's the best way of managing this to prevent disease progression and to aid recovery. Now that's where the evidence based medicine comes in, knowing whether the drugs we use for example are worthwhile using, whether they do actually aid recovery, whether there are things that we should be doing to try and prevent a worsening of the condition, so that's one side of it. I think there's a fair bit to the art side as well though, when it comes down to the bottom line it doesn't matter how acupuncture works if it makes people feel better and doesn't do any harm then I don't see any problem with that.<sup>46</sup>

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<sup>44</sup> Rees, J. (1995). *Ibid.* p.852.

<sup>45</sup> Dr 12.

<sup>46</sup> Dr 24.



A similar dichotomy can be found in the account of Dr 1. He explains his perceptions of a role for an evidence based approach and its relation to his model of clinical practice and development of hypnotherapy:

Interviewer: So where does your complementary therapy fit in this evidence-based approach?

I think it kind of explains where I am with the whole thing. There has to be an element of belief there and I believe there is a place for evidence-based medicine. I believe that the sort of medicine we practise - traditional western medicine - is appropriately based upon scientific principles but I also happen to believe that there is an altered level of consciousness that you can enter in a hypnotic state and while you're in that altered level of consciousness you are more amenable to suggestion. I believe that to be the case, I believe it helps some people, I've tried it with some people and it has helped.<sup>47</sup>

Here EBM and the complementary therapy of hypnotherapy are projected as compatible in practice. While the GP suggests they may exist side-by-side, there is a presentation of hypnotherapy as *beyond* a strict EBM approach. He later restates this point in a more direct way:

I don't think there's anything wrong with applying the evidence-based principles to alternative therapy, I think one should. I don't think however that at the moment one should necessarily expect astonishingly encouraging results. Simply because you can't do that I don't think you necessarily need to abandon it

Interviewer: Why is that?

Because the, in those sorts of clinical situations you need to be able to define some clear outcome indicators if you like and because of the nature of what you're doing it's very difficult to have clearly defined outcome indicators so until you can do that you're not going to get any good evidence, anything that's really hard and reliable but that's not to say that we shouldn't keep trying. However, if you believe that it works then you should keep on doing it.<sup>48</sup>

In this quote above, EBM is not seen as inherently opposed to complementary medicine, but as insufficiently developed as a system of guidelines to support the

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<sup>47</sup> Dr 1.

practice of such therapies.<sup>49</sup> While some medical supporters of complementary therapies have attempted to jump on the bandwagon of EBM, drawing upon the rhetorics of this movement to justify low-level treatments<sup>50</sup> and placing therapies such as homeopathy under the scrutiny of meta-analysis,<sup>51</sup> others (supporters of EBM) have branded complementary therapies as an obstacle to the further development of clinical practice based upon the principles of EBM.<sup>52</sup>

Quote #34 also helps illuminate another rhetorical device identified in a number of GP accounts. There is an objection to the claim that treatment outcomes and the efficacy of specific treatments be contained strictly to measurable data. Formal literature has outlined this feature of EBM: ‘an implicit assumption within evidence-based medicine is that it will provide us with much *harder* data upon which to decide how to manage patients’.<sup>53</sup> The GPs’ claims that medical practice can not be strictly measured portrays the medical encounter as undervalued or neglected in the medical model of EBM. Similarly, writers have objected to the quantitative approach which they see as inherent in EBM and some have classified a strict evidence-based approach as deficient in that it ultimately denies the more qualitative aspects of medical practice.<sup>54</sup> In addition, this debate over the legitimacy of evidence for EBM and the assessment of treatments has also captured the attention of some supporters of complementary therapies within the medical context.<sup>55</sup>

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<sup>48</sup> Dr 1.

<sup>49</sup> This rhetorical construction fits comfortably alongside the GPs’ talk of a pragmatic approach to medical care generally and complementary therapies more specifically as outlined in chapter five.

<sup>50</sup> Lewith, G. (1996). ‘The Use and Abuse of Evidence-Based Medicine: An Example from General Practice’. In E. Ernst (ed.). *Complementary Medicine: An Objective Appraisal*. Oxford, Butterworth Heinemann.

<sup>51</sup> Reilly, D. *et al.* (1994). ‘Is Evidence for Homeopathy Reducible?’. *Lancet* 2: 1066-7

<sup>52</sup> Audit Commission (1996). *What the Doctor Ordered: A Study of GP Fundholders in England and Wales*. London, HMSO.

<sup>53</sup> Lewith, G. (1996). *Op. Cit. No. 49.* (my emphasis) p.107.

<sup>54</sup> For examples see Greenhalgh, T. (1995). *Op. Cit. No. 2.* Lewith, G. (1996). *Op. Cit. No. 49.*

<sup>55</sup> Lewith, G. T. (1996). *Ibid.*.

As outlined in chapter six, holism is constructed by many of the GPs as involving a deeper exploration of the patient's social or life circumstances and empowering patients to take more responsibility for their health and to take a more active role in the medical consultation. Accompanying these constructions is an insistence that GPs listen more to patients and treat patient's experiences about their complaints as legitimate contributions to help guide clinical practice. These presentations are further drawn upon as a means of claiming a need to move beyond a strict evidence-based approach to general practice. Some of the GPs construe EBM as a barrier to developing a concern with the wider 'social' circumstances of patients.<sup>56</sup>

As Dr 1 claims:

I'm interested in people's problems and what they do and they're often very unscientific but I think it's important to in a lot of the work that we do to have that sort of scientific grounding being prepared to deviate from that but having a scientific grounding. I don't believe for instance that evidence based medicine is the be all and end all of medicine.<sup>57</sup>

And Dr 12 outlines a similar position when he states:

being holistic is taking all the factors, you know, the patient's personality and their family all of that into account and not thinking that everything is in this little model where it's pharmacologically wise and you try this and you know I think there are obviously GPs who are like that, who just think I'm here to give them, but that's a very small percentage the vast majority are understanding and actually listening to what a patient says, you know, trying to properly empathise with them is very important as well.<sup>58</sup>

As Gordon claims the rhetorics of science and art have often been employed in varying degrees or mixtures to describe medical practice.<sup>59</sup> Most of the GPs who talk

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<sup>56</sup> To refer back to quote #31 and the account of Dr 15 he defines EBM as an attack upon 'pastoral care' and 'gradually the demise of general practice'.

<sup>57</sup> Dr 1.

<sup>58</sup> Dr 12.

<sup>59</sup> Gordon, D. (1988). *Op. Cit. No. 16*. And Weatherall suggests this is also the case with reference to specialists, see Weatherall, D. J. (1995). *Science and the Quiet Art: The Role of Medical Research in Health Care*. Oxford, Oxford University Press. Also with reference to clinical medicine in the U.S. see Komaroff, A. L. (1982). 'Algorithms and the 'Art' of Medicine'. *American Journal of Public Health* 72: 10-12.

of EBM in this study draw upon both of these rhetorical devices to explain their practice. Yet, there is also within the accounts an association of EBM with an extreme position of ‘scientism’ and, in contrast, of general practice and the GP’s particular clinical work with those crucial aspects of medicine which accompany yet are distinct from the scientific. There is an appeal within the accounts to a *balance* between the art and science of medical practice and it is feared that EBM advocates a replacement for the art of medicine and treats science as a satisfactory or superior substitute for the doctor’s clinical experience. In this sense, EBM, like the specialisms of lay therapy and hospital medicine, is portrayed as overly dogmatic, rigid, based upon a narrow vision of the meaning of medicine, and unrealistic and detached from concrete practice. As Dr 15 explains his perception of EBM, ‘I’m not convinced. I’m not convinced it’s a better way of looking after people *in the real world*’.<sup>60</sup> Equally, as with the boundary work relating to these other professional groups, general practice is contrasted to EBM in terms of being a field of medical practice which is patient-centred and therefore free from the bias of self-interest. Furthermore, these notions of self-interest and detachment from the real concerns of patients as assigned to the evidence based approach are compounded by a presentation of EBM as orchestrated and headed by specialists themselves.<sup>61</sup> EBM is seen, by some of the GPs, as an approach to medicine that has been thrust upon the community of general practice by other sectors of the profession who are not so much interested or involved in clinical practice but who are engaged in the academic activity of research. Dr 15 employs these discursive constructions in relation to EBM when he explains:

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<sup>60</sup>Dr 15.

<sup>61</sup> However, it must be noted that many of these GPs do acknowledge that there is support for EBM from some other grass-roots practitioners in general practice.

I'm aware [evidence-based medicine] is coming at us. There's something building and something about good practice and that sort and I think it's coming out of people who have special interests

Interviewer: What might they be?

Like I'm interested in lipids. I really like that I'm interested and doing a lot of research in lipids and I spend a lot of time and I get paid for doing it and therefore I start looking at the best way of doing that.<sup>62</sup>

This same GP presents a similar construction of EBM later in his account. Here, he describes a disagreement between himself and one group of specialists (geriatricians) as how best to treat hypertension in his elderly patients. This quote again illustrates how allegiance to EBM is employed as a means of constructing discursive demarcations. He states:

I had a big discussion with the geriatricians the other day about treating hypertension and if I were to treat hypertension the way they want something like seventy percent I think of my elderly population would have been on drugs. I can't see it, this doesn't make sense to me that that is what the implication is of evidence based medicine, I just don't believe it's true.<sup>63</sup>

Another rhetorical device employed to similar effect is to link EBM to a notion of an unfair and uneven professional power struggle within the wider medical community. Consultants and academics within medicine are projected as heading the hierarchy for funding and EBM is cynically seen as a strategy by which these more prestigious groups maintain their dominance. Dr 25 provides a detailed outline of how she sees EBM:

I'm very sceptical of if we look at our evidence base for anything it is based on pharmaceutical industry's funding so we need to go back to the source of the funding that commissions the research that makes the Government process that empowers people to have enough status to apply for grants to study evidence-based medicine, its all a bit of a set up ain't it. I'm a total cynic. Evidence-based medicine is about the last bastion of professionals retaining their power structure

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<sup>62</sup> Dr 15.

<sup>63</sup> *Ibid.*.

Interviewer: Can you explain that to me?

I see it in that way as its almost like professionals retreating into we're the only people who have the skills to interpret the multiple layers and the meta analysis and its like the people who are the academics or consultants retaining on but to do that kind of thing, to do meta analysis or reviews you must have the ability to attract the grant funding to do that so it keeps them up there at the top.<sup>64</sup>

Again, as illuminated in previous extracts, these rhetorical devices help project general practice as separate from the self-interest that is presented as motivating other professional medical groups. Analysis of another GP's account illustrates the use of similar discursive constructions. As in the case of Dr 15, this GP associates EBM with the work of consultants. He claims:

I think that now they're starting to come up with evidence based medicine, they'll start doing more and more and you'll learn more information and new things will be changed but a lot of it is just consensus guidelines by, you know, consultants who actually aren't there, so you actually take it all with a bit of a pinch of salt.<sup>65</sup>

This GP continues this section of talk by contrasting this detached approach of consultants - 'who aren't actually there' - to the art of medical practice that doctors like himself employ on a day-to-day basis. In this particular extract of talk the art of general practice is explained as the ability to decide whether patients are suitable for particular treatments and as to whether they are likely to comply to prescription orders - decisions that can only be informed by everyday practice and dealings with patients. He puts it like this:

like you would get all these guidelines saying they should be on this, that means they should be on that and that's not, that's fine when you know, when you look at prescriptions, I mean for every three out of four prescriptions I only dispense you know so twenty-five percent of prescriptions that I give are never actually taken by patients you know you go to patients' houses and you

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<sup>64</sup> Dr 25.

<sup>65</sup> Dr 12.



see their cabinets full of tablets, you know, so it's, that's what I mean by the art, the perception of people that will take this or not take that.<sup>66</sup>

And Dr 25 also explains how she sees EBM (and thereby the consultants who support the movement's development) as distanced from clinical practice when she says, 'if you're gonna have the time to construct and read an analysis or the political power to get grants to employ other people to do this for you *by definition you ain't seeing many patients*'.<sup>67</sup>

Again, as seen elsewhere in the analysis, these GPs demarcate contrasting sets of rhetorics (the theoretical and academic medicine of EBM and the more pragmatic perspective of general practice based upon clinical experience in the field) to help construct boundaries and demarcations between themselves and other professional groups both within and outwith the medical profession. The GPs suggest that EBM may be a theoretical ideal but not necessarily a good dictate for practice. As Dr 12 puts it, 'I think evidence based medicine sounds very nice in theory',<sup>68</sup> and Dr 2 suggests, 'we'll we're talking about evidence based medicine and that's a very nice concept but to a hard and fast figures and that it's much more difficult'.<sup>69</sup> Another GP also iterates this perception but this time in relation to a more general application:

well I think general practitioners have an, you know, you feel you're working at the coal face and you feel a lot of things that are great in theory don't work in practice, you know, so you don't always accept the theoretical and the scientifically proven because what's important is what works in practice.<sup>70</sup>

These rhetorical claims are echoed in more formal criticisms of EBM. Here again is a construction of EBM as naively unaware of the complexities of everyday practice. EBM is seen as a theoretical ideal which, while signifying a 'challenging

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<sup>66</sup> Dr 12.

<sup>67</sup> Dr 25.

<sup>68</sup> Dr 12.

<sup>69</sup> Dr 2.



innovation' and a 'summit of aspiration' for clinical practice, is not always suitable or possible to deploy 'in the foothills' of general practice.<sup>71</sup>

Much of this criticism of EBM which is presented by these grass-roots practitioners has been acknowledged by Sackett et al and others.<sup>72</sup> In more recent years these writers have attempted to appreciate the professional opposition to the EBM approach and much of their latter day work has been a response to such criticism, often taking the form of clarifying their position and recontextualising the objectives of EBM.<sup>73</sup> These refinements have involved two broad themes. First, there has been a claim that opposition from individual grass-roots practitioners to EBM is motivated by outdated professional self interest and misunderstanding. These writers suggest doctors are reluctant to relinquish the authority that is currently gained from seniority in an hierarchical professional community.<sup>74</sup> In this sense, EBM is constructed as a progressive movement rolling back the conventions of medical practice and opening up the profession to democratic reform.<sup>75</sup>

In contrast, there have also been attempts from within the EBM movement to incorporate a more balanced mix between the rhetoric of science and that of clinical experience with an aim to overcoming the fears of clinical practitioners. Individuals spearheading the EBM movement have moved away from a position which advocates clinical science alone (although they deny such a stance was ever their intention) to one where they recognise the significance of clinical experience and accommodate

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<sup>70</sup> Dr 7.

<sup>71</sup> Jones, K. (1996). [Book Review]. 'Evidence-Based Medicine'. *British Medical Journal* 313: 1410.

<sup>72</sup> Sackett et al. (1996). 'Evidence-Based Medicine: What it is and What it isn't'. *British Medical Journal* 312: 71-2. Grayson, L. (1997) *Op. Cit. No. .*

<sup>73</sup> Sharp, D. (1996). [Book review]. 'Evidence-Based Medicine'. *Lancet* 348(8983): 1297.

<sup>74</sup> Rosenberg, W. and Donald, A. (1995) *Op. Cit. No. 3*. Grayson, L. (1997). *Op. Cit. No. 1*. Some social scientists have also associated the prevalence of clinical expertise with professional hierarchy. Armstrong, for example, writes of 'hierarchy based upon expertise', Armstrong, D. (1977). 'Clinical Sense and Clinical Science'. *Social Science and Medicine* 11: 599-601.

this feature of medical practice accordingly within their work. Sackett et al acknowledge that some critics of EBM are fearful of the approach ‘suppressing clinical freedom’<sup>76</sup> and in response suggest ‘external clinical evidence can inform, but can never replace clinical expertise’<sup>77</sup> and Grayson reiterates such a concession when she states, ‘evidence based medicine is not mindless cook-book medicine but a means of enhancing traditional clinical skills through better information’.<sup>78</sup> This refinement of approach has also introduced the theme of patient preference into the model for evidence-based clinical decision making<sup>79</sup> and has also, of course, injected a renewed significance for the role of practitioner in clinical practice, conceiving of the practitioner as irreplaceable by computer or machine.<sup>80</sup> Accompanying these recent claims, some proponents of EBM also appear to have relaxed their insistence upon the randomised controlled trial as the only legitimate method of establishing good scientific evidence.<sup>81</sup> However, others have reiterated the belief that randomised

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<sup>75</sup> It is interesting to note that it is this heroic rhetorical style partly helped foster distrust and caution of EBM from within the ranks of the profession in the first place.

<sup>76</sup> Sackett *et al.* (1996) *Op. Cit. No. 72*. p.71.

<sup>77</sup> Sackett *et al.* (1996) *Ibid.* p.72.

<sup>78</sup> Grayson, L. (1996) *Op. Cit. No. 1*. p.52.

<sup>79</sup> Hope, T. (1995). *Report to the Anglia and Oxford Health Authority into the Use of Evidence-Based Information for Enhancing Patient Choice*. Old Road, Headington, Oxford, Anglia and Oxford Health Authority. To elaborate this stress upon patient preference, as Haynes et al state, ‘Patients have always exercised their preferences for care by seeking second opinions, choosing alternative therapies, preparing advance directives, and adhering to prescribed treatments. Moreover, today’s patients have greater access to clinical information than ever before, and some become more knowledgeable than their practitioners. Although the patient’s role in clinical decisions is usually not formalised and is sometimes overridden or ignored by practitioners, it is nevertheless an important component in most decisions, particularly with self-administered treatments. The importance of patient preferences is recognised in the emerging discipline of evidence-based patient choice, an approach to decision-making that deserves its own discussion’. Haynes B. *et al.* (1996). ‘Transferring Evidence from Research into Practice: 1. the Role of the Clinical Care Research Evidence in Clinical Decisions’. *Evidence-Based Medicine* (1)3: 196-198. p.197.

<sup>80</sup> Haynes, B. *et al.* (1996). *Ibid.* Interestingly, both of these issues - patient preference and doctor as irreplaceable - are central to the rhetorical constructions of most of the GPs’ accounts analysed in this section.

<sup>81</sup> Sackett *et al.* (1996). *Op. Cit. No. 72*. On a more general level the Lancet has more recently vowed to oppose meta-analysis in its clinical trial reports. See Editorial (1986). ‘Intravenous Beta-Blockade During Acute Myocardial Infarction’. *Lancet* (ii): 287.

controlled trials remain the hallmark or 'gold standard' for assessing the efficacy of treatments.<sup>82</sup>

Despite these responses and refinements from the proponents of EBM some sections of the medical profession remain unconvinced and opposed to EBM, as Lipman *et al.* have recently commented; 'many [general practitioners] seem to believe that [evidence-based medicine] is no more than the implementation of evidence-based guidelines or that it is the province of 'experts' and that it is not possible to incorporate it into their routine practice'.<sup>83</sup> Writers have identified what they see as an inherent contradiction or tension within the newly espoused integration of scientific and artistic rhetorics from within the EBM camp. Smith, writing in the British Medical Journal, outlines these difficulties and as a consequence suggests that medical practice must essentially be seen as 'an art supported by science'.<sup>84</sup> He states:

clinical skill is essentially derived from experience and is expressed as judgement in decision-making. But the variation in the ways in which different individuals interpret experience and formulate judgements renders this aspect difficult to expose to 'big statistical ways of thinking'. It is therefore difficult to apportion scientifically the appropriate use of 'best available clinical evidence' in any particular decision process. We are thus led back or on to a wider view of medicine as a humane art that is supported by science.<sup>85</sup>

This rhetorical construction of medical practice falls in line with that presented by many of the GPs referred to in this section who claim their clinical work involves a combination of both art and medical science. However, as we have seen in the course of this chapter other GPs are more critical of the EBM approach and oppose any attempts to develop the approach within general practice.

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<sup>82</sup> Grayson, L. (1996) *Op. Cit. No. 1*. Also see Tovey, P. (1998). 'Narrative and Knowledge Development in Medical Ethics'. *Journal of Medical Ethics* 24(3): 176-181. As Tovey points out, 'evidence-based medicine is increasingly directing research and practice, and the randomised controlled trial remains dominant in the collation and definition of that evidence base', p.177.

<sup>83</sup> Lipman, T. *et al.* (1997). *Op. Cit. No. 7*. p.133.

<sup>84</sup> Smith, B. H. (1996). *Op. Cit. No. 30*.

<sup>85</sup> Smith, B. H. (1996) *Ibid.* p.169.

## 7.4 Summary and Conclusions

Before summarising and concluding the analysis presented in this section so far I would like to first draw attention to the ways in which the GPs' talk outlined in this chapter can be contextualised within the wider professional strategies outlined in chapter six relating to the boundary work between general practice and hospital medicine.

Support for EBM within the primary care environment, in the sense of representing a part of a wider trend to reduce clinical practice and decision making to a clinical science that is more rational, standardised and explicit, can be interpreted as an attempt by some within general practice to enhance the status of the profession in relation to hospital medicine. This strategy seeks to gain such status strictly in terms of the dominant hospital paradigm and as such stands alongside other developments to foster a more 'scientific' approach to general practice such as the development of minor surgery.<sup>86</sup> As Greenhalgh asserts with reference to certain premises of the evidence-based approach and its relation to the general practice community:

(EBM) has created a somewhat spurious divide between those who seek to establish general practice on an equal 'scientific' footing to that of the secondary care sector, and those who emphasise the value of the intuitive, narrative, and interpretative aspects of the consultation.<sup>87</sup>

Seen in these terms, the construction of EBM by these GPs illustrates how these doctors not only attempt to further demarcate themselves from hospital medicine but also attempt to defend a vision of general practice and a medical role which are currently contested by others within their profession.

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<sup>86</sup> See chapter six section six for discussion of such developments.

<sup>87</sup> Greenhalgh, T. (1995). *Op. Cit. No. 2*. p.958.

The clinical freedom of individual general practitioners plays a central role in their continuing control of medical knowledge<sup>88</sup> and as Gordon suggests, 'while science may be considered a symbol of legitimacy and source of power for the medical profession, physicians' clinical expertise may be regarded as their personal power and private magic'.<sup>89</sup> As this section has illustrated some of the GPs practising complementary therapies describe EBM as a recent movement which threatens the intuitive, artistic and holistic hallmarks of good general practice. In addition, the presentations of EBM as detached from clinical practice, based upon a narrow definition of illness and medicine (both in research and practice) and as divorced from the needs and demands of individual patients are also employed by these GPs to further deauthenticate the evidence-based approach to the general practice setting.

Some GPs explain EBM as an out and out threat to their clinical freedom and therefore as an approach that should be banished from general practice. Meanwhile, others explain EBM as a development which may be productively drawn upon by general practice but only if supplemented by clinical expertise and if tacit medical knowledge is assigned its rightful place at heart of good effective clinical work. While this second position acknowledges a role for EBM in general practice it nonetheless maintains clinical expertise as a prime and essential foundation of clinical practice.

These GPs' accounts illustrate an internal response from within this particular subworld (of direct integrative practice) to the attempts by some established authorities within the medical profession to increase the *visibility* of GPs' practices -

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<sup>88</sup> Allsop, J. (1995) *Op. Cit. No. 11*. p.83. Elston also expresses this point. She classifies the freedom as 'clinical autonomy' or 'technical autonomy'. See Elston, M. A. (1991). 'The Politics of Professional Power'. In J. Gabe, M. Calnan and M. Bury (eds). *The Sociology of the Health Service*. London, Routledge.

<sup>89</sup> Gordon, D. (1988). *Op. Cit. No. 16*. p.257.

to employ the words of Strauss, this particular internal response 'take(s) the form of attempts to ward off or minimise external regulation'.<sup>90</sup>

As this chapter illustrates, the very discourses which are employed by these GPs to defend their clinical autonomy from the threat of EBM are those which are employed elsewhere in their accounts as justifications and explanations for the integration of complementary therapies within their practice. Furthermore, some of the GPs draw more directly upon complementary therapies to help illustrate how EBM is unsuited to legitimate and good general practice. Holism would appear to play a powerful part in the GPs' attempts to render EBM either deficient or irrelevant to the practice of individual GPs. The clinical freedom of the practitioner to choose from a wide range of therapeutic and treatment options as a means of tailoring clinical practice to the needs of individual patients is seen by these GPs as a necessary characteristic in providing effective and responsive general practice. Moreover, complementary therapies are presented as fundamental to this picture of general practice in that they represent one avenue of treatment that should be included in this model of clinical freedom and also help foster practice that is in tune with the unique needs of individual patients.

Despite the more recent attempts of EBM proponents to allay fears among general practitioners about the evidence-based approach, it would appear from the analysis of the accounts presented here that some GPs remain defiant to these developments and, as such, EBM may face continued opposition from certain sections of the general practice community in the foreseeable future. As has been shown, unconventional medicines represent a rich resource with which these doctors defend

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<sup>90</sup> Strauss, A. (1978). 'Social Worlds and their Segmentation Processes'. *Studies in Symbolic Interaction* 4: 125-139. p.126.

their clinical autonomy from what they see as the threat of the EBM movement. As such, unconventional therapies help these doctors maintain and enhance an important source of authority and power both within the medical community and the wider medical arena.



## **Chapter Eight**

### **Concluding Discussion**

## 8.1 Introduction

This chapter draws together the main features of the analysis into a number of concluding themes to illustrate the contribution of the research to both an understanding of the substantive topic of direct integrative practice and a critical awareness of different theoretical perspectives and concepts.

As explained at the end of chapter two, the study has been organised around a number of specific research questions and, having presented the analysis of the GPs' accounts in previous chapters, the thesis now outlines the answers provided by the thesis to these questions. This chapter demonstrates that the study of the GPs' talk contributes much to our understanding of some of the contemporary changes affecting the relationship between conventional and unconventional medicines and their respective practitioners.

The research provides the first in-depth investigation of the rhetorical features of the medical subworld formed around direct integrative practice; the analysis reveals the core rhetorical tools – interpretative repertoires, arguments and boundary-work – with which these practitioners explain and justify aspects of their unconventional practice. Charting these rhetorical features is in itself a major contribution to the study of the integration of complementary therapies within general practice; no previous work in this area has focused attention upon these features.

Yet, the aim of this thesis was set beyond simply identifying the rhetorical features of this subworld; the thesis has also been concerned to contextualise these features within the wider political arena of health care. Indeed, the analysis also reveals a number of ideological strategies that underlie and feed into the doctors' presentations. These strategies help guide the concluding themes presented in this chapter. First, the chapter explains how certain features of the GPs' talk illustrate a

defensive strategy whereby these doctors defend their professional dominance in the face of the threat posed by lay therapy. These findings provide general support for Saks' conclusions from previous study.<sup>1</sup> However, as the section goes on to explain, the findings produced from the present research also supplement Saks' work, revealing characteristics of this defensive strategy previously neglected in his research.

The chapter then goes on to outline two more positive professional strategies which link to the GPs' accounts of their complementary medicine: interprofessional strategy based upon a GP/Hospital divide and intraprofessional strategy relating to the rise of evidence-based medicine within general practice. These findings illustrate that direct integrative practice does not accomplish just one ideological task for these GPs. But, in contrast, the GPs' explanations of their unconventional therapies are orientated towards a number of diverse concerns which currently occupy many within the ranks of general practice and beyond.<sup>2</sup> As section three demonstrates, these conclusions move the thesis beyond the constraints of Saks' study and help illustrate the shortcomings of such previous work examining integration.

Another set of findings identified from the analysis relates to how these GPs transport unconventional therapies from beyond to within the borders of their professional community. Section four explains how the details of this transportation are illuminated from the research and how this, again, is another area of integration which has hitherto been neglected in previous work.

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<sup>1</sup> Saks, M. (1995). *Professions and the Public Interest*. London, Routledge. Saks, M. (1996). 'From Quackery to Complementary Medicine: The Shifting Boundaries Between Orthodox and Unorthodox Medical Knowledge'. In S. Cant and U. Sharma (eds). *Complementary and Alternative Medicines: Knowledge in Practice*. London, Free Association Books.

<sup>2</sup> Bowling, A. (1981). *Delegation in General Practice*. London, Tavistock. Jefferys, M. and Sachs, H. (1983). *Rethinking General Practice*. London, Tavistock.

Redirecting attention away from the direct examination of professional strategies, section five discusses two rhetorical features – flexibility and contingent/non-contingent repertoires – which are identified from the GPs' accounts. Again, as with other findings from the study, this is an area that has not been explored in previous study and, as such, comprises a unique and major contribution of the thesis to understanding how GPs attempt to maintain and enhance their dominance in relation to unconventional medicines.

However, the research not only produces significant empirical findings relating to GPs' direct integrative practice, but also contributes to the development and refinement of various theoretical traditions within sociology. The novel focus of the study and its ability to contribute to an understanding of the substantive topic of direct integrative practice is only made possible through the adaptation and application of the particular theoretical framework outlined in chapter two (a framework consisting of a combination of selected features primarily from SWT, boundary studies, discursive psychology and rhetorical psychology amongst others). This theoretical framework has never before been employed to examine either unconventional medicines or, more specifically, their integration within GP surgeries; the thesis provides an original contribution to knowledge in this area. Acknowledging this point, the chapter outlines the major strengths of the different theoretical perspectives in as much as they help to conceptualise and understand the data collected for this case study. Discussion of these strengths is interspersed throughout the presentation of the empirical findings at relevant points in the chapter.

Yet, the study does not employ these different theoretical perspectives uncritically. In the course of the research the thesis has modified numerous approaches and the chapter outlines certain shortcomings of theoretical perspectives

as exposed by the findings from the study. Finally, the chapter goes on to consider some of the limitations of the research and closes with an outline of some of the possibilities for future study which will complement the findings revealed from the thesis and help further understand the contemporary relationship between unconventional and conventional medicine and their respective practitioners.

## **8.2 Defensive Strategy**

As outlined in chapter one, previous work has explained the incorporation of unconventional medicines by doctors as part of an attempt to quash the threat posed by non-medical therapists to the authority and dominance of the medical profession. Saks concludes from his research that the changing approach of the medical profession towards unconventional therapies - from outright criticism and ridicule to toleration and consideration of the therapies for practice – can be understood primarily as a defensive strategy serving the self-interest of the medical profession and particularly the medical elite.

Some of the findings from the thesis support Saks' conclusions. However, it must be remembered that the research differs in focus from the one adopted by Saks in his work. Whereas Saks concentrated his efforts upon the approach of the medical elite towards unconventional therapies, the present analysis centres upon the accounts of grass roots doctors. Furthermore, Saks' work deals with the medical profession as a homogenous community while the thesis focuses attention upon one particular branch of medicine – general practice. As a result, the findings from this study move a step further than those produced from previous work. The research not only identifies the defensive strategy of the medical profession regarding incorporation, but also sheds light on some of the very rhetorical tools whereby doctors attempt to quash the threat

posed by non-medical practitioners. For example, some GPs highlight what they see as the danger of lay therapists to patients:

referring to a non-medically qualified, I'm quite unhappy about because I have had anecdotal evidence of patients who have had tumours who have been going for homeopathic treatment. The lay person hasn't known enough to pick up that there's been something wrong and the patient's been very unwell.<sup>3</sup>

With a firm focus upon the grass roots of general practice - the analysis reveals how the GPs' accounts provide examples of the day-to-day accomplishment of such defensive strategy and thereby supplement Saks' earlier thesis.

There are two general sets of findings produced from the present research which provide further evidence to support Saks' thesis. First, a major finding identified from the GPs' accounts is the presentation of a boundary between themselves and lay therapists. This boundary-work, predominant across all GP accounts, is established around a core demarcation between what the GPs argue are two contrasting styles of practice associated with unconventional therapies. On the one hand, these GPs present their own style of practice as complementary, while on the other, lay therapists are seen as engaged in alternative therapy and are classified as alternative therapists. As revealed in chapter four, the doctors draw upon a number of contrasting rhetorics and claims in their attempts to demarcate these two general styles of practice and practitioners.

A second set of findings from the study also supports Saks' thesis regarding incorporation. The lay practitioner/GP divide – built primarily upon a distinction between complementary and alternative styles of practice – is further enhanced by the GPs' portrayal of their own clinical reality. The doctors outline a piecemeal role and restricted scope for unconventional therapies presenting them as supplementary and add-on treatments for use in combination with conventional medicines rather than

interpreting them as self-sufficient systems of medicine in their own right. For example, as Dr 19 explains: "I think you can...use [acupuncture] as an adjunct to western medicine to treat a lot, a wider range of things but I would never see acupuncture as being a whole system by itself".<sup>4</sup> Here we can identify a repetition of the complementary style of integration advocated in the lay practitioner/GP divide.

Yet to demarcate these two styles of unconventional practice and also general practitioners from lay therapists does not *necessarily* constitute the type of defensive strategy claimed by Saks. However, analysis of the GPs' talk directs us to another rhetorical feature that builds upon and enhances the divide between two contrasting styles of therapy. The doctors in the study do not simply demarcate themselves and their practice from that of lay therapists. We can see from the analysis of the grass root doctors' accounts that a significant proportion of their talk is directed towards *attacking* the world of lay therapy. Such an attack is accomplished by drawing upon a range of contrasting rhetorics and claims such as safety/risk and scientific foundation/non-scientific foundation amongst others. The talk of Dr 20 illustrates these rhetorics when he states:

what worries me a lot with the lay homeopathic person is, er, not getting the diagnosis right, you know a lot of, I suppose my medical knowledge is are you dealing with something serious?...I've seen people who have come to me having had lay homeopathy and they've come to me with a set of symptoms, you know, for years and I've examined them and found serious illness. Now that worries me a lot.<sup>5</sup>

In effect, this criticism of lay therapy supports Saks' interpretation that incorporation is motivated, partly at least, by a defensive strategy based upon self-interest. To claim superiority for complementary over alternative style practice is to claim a direct and central role for general practitioners in unconventional therapy and,

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<sup>3</sup> Dr 23.

<sup>4</sup> Dr 19.



furthermore, can be interpreted as an attempt from within the medical profession to monopolise unconventional practice for those within medical boundaries.

Now what is particularly significant about these findings is not only that they add weight to Saks' general conclusions regarding incorporation, but that they also highlight the strengths of the theoretical framework developed in the present study to understand the mechanisms of incorporation in more detail.

As the analysis reveals, a change in focus of approach from the pronouncements of the medical elite to the talk of rank-and-file GPs allows the very rhetorical tools underpinning the GPs' defensive strategy to be uncovered and investigated, thereby supplementing as well as supporting Saks' previous work. For example, the analysis reveals how the GPs employ the rhetorics of risk and danger and self-interest amongst others to attack non-medical therapists and their practice.

This point also illustrates the strength of Gieryn's notion of episodes of boundary work in aiding an understanding of the contemporary characteristics of incorporation. Saks implicitly draws upon a notion of boundaries with his distinction between the medical profession and those therapists of alternative medicines located outside the medical community. Yet, Saks fails to expose this boundary to detailed examination. Conversely, my work is located in the current boundary theory formulated by Gieryn and his concepts of boundaries and episodes of boundary-construction have been employed to reveal how those within the medical profession actually accomplish such demarcation and distancing strategies in their talk. This is a position which has much to offer given the rhetorical nature of the accounts which the GPs in the study produced. An example of such demarcation is provided by Dr 2 when he states: 'I'm not a homeopath I'm an allopath who uses homeopathy'.<sup>6</sup> As

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<sup>5</sup> Dr 20.

<sup>6</sup> Dr 2.

analysis of the data reveals, the lay therapist/GP boundary is a core rhetorical feature of these GPs' accounts and one which plays an important ideological function in relation to the ongoing struggles between different groups of health care providers.

These findings based upon the GP/lay therapist boundary construction also illuminate the suitability and valuable contribution of another feature of the theoretical framework for appreciating the GPs' accounts. Identifying the doctors' distancing tactics - attacking and criticising lay therapists and their practice - is a process central to both a Social World perspective and Billig's rhetorical psychology. To explain, SWT conceptualises competing worlds battling over cultural authority and resources within an arena. In such battles worlds present their own practices, technologies and members in favourable terms while also attacking key characteristics of other worlds. The GPs' distancing tactics regarding lay therapy are a good example of how the conventional medical world attempts to dominate unconventional practices through delegitimising the activities of the rival world of unconventional medicine.

Similarly, according to Billig, all claims and arguments of speakers are set alongside competing claims and counter-arguments. Although pitched at a more micro level of analysis than SWT, this approach of Billig also conceptualises criticism and attack as an inevitable feature of informants' accounts, a rhetorical feature clearly illustrated from the analysis of the GPs' talk.

As we have seen in this section, the thesis has produced some findings which support the general thesis posited in earlier work by Saks. The analysis illustrates how certain rhetorical features of the GPs' accounts are directed not just towards incorporating unconventional therapies but, more significantly, to also monopolising the practice of these other medicines. In this sense, the GPs' talk is directed towards

quashing the threat posed by non-medical therapists to the dominance of the medical profession.

These findings are particularly interesting given the different orientation of the thesis in relation to earlier work examining incorporation. This section has discussed not only some findings from the study which support and further enhance the conclusions of Saks, but also illustrated some of the insights gained from approaching the topic of incorporation from the new theoretical perspective developed in the present work. On the one hand, SWT provides a structural framework (based around the conceptualisation of competing worlds of medicine) which is extremely well suited to and useful for interpreting and explaining the defensive strategy of the GPs in a wider political context. Meanwhile, the analysis of the transcripts also shows some of the advantages of adopting key tenets of discursive and rhetorical psychology. These approaches encourage the first in-depth exploration of the rhetorical tools with which these GPs perform the defensive strategy against lay therapy.

### **8.3 Positive Strategy**

So far, the chapter has outlined those findings that generally supplement Saks' interpretation of incorporation in terms of defensive strategy. However, the application of the new theoretical framework also directs us to other findings from the study. These are findings which do not directly support Saks' conclusions but instead reveal how additional more positive ideological tasks and strategies also underlie and feed into the GPs' descriptions and explanations.

What is conclusive from the analysis produced in this thesis is that the development of direct integrative practice by general practitioners is not fuelled

simply by the need to defend the medical profession from outside challenges. In addition, contextualising the GPs' accounts in terms of ongoing struggles between subgroups within the medical community highlights the role of complementary therapies in other significant professional battles. Describing and justifying complementary medicine (like any other subject of talk) has no single purpose; instead, the descriptions and explanations of unconventional therapies by general practitioners are orientated towards a number of diverse concerns which currently occupy many within the ranks of general practice and beyond. In addition to the defensive strategy centring around the GP/lay therapy divide, the research also identifies two types of positive strategy from the analysis of the GPs' talk: that relating to interprofessional struggles and that directed to intraprofessional struggles. The chapter now turns to a discussion of each.

### **8.3.1 Interprofessional Strategy**

In addition to the GP/lay therapy divide, the analysis of the GPs' accounts also reveals another central boundary construction. Much of the doctors' talk presents a distinction between general practice and hospital medicine. The research identifies a number of central rhetorics which are drawn upon by the doctors to demarcate and distance themselves from the medicine and practitioners found in the hospital setting. Basically, the GPs portray their clinical practice as patient-centred, holistic, artistic and intuitive. This is contrasted in the accounts with the academic and overly scientific medicine practised in hospitals. For example, as Dr 6 explains:

I thought I wanted to do hospital medicine. I did paediatrics and I looked at the consultant paediatricians and thought really I don't want to end up like that

Interviewer: Why? How had they ended up?

Unsympathetic...very in an ivory tower and a bit detached from reality.<sup>7</sup>

Again, as with the demarcation between general practice and non-medical therapy, Gieryn's concept of boundary-work proves valuable for interpreting this area of the GPs' presentations. Focusing on the concept of boundaries within the analysis helps us to understand how the interprofessional division between primary care and the hospital is actually accomplished and managed by grass roots practitioners.

Now, what is so interesting about this boundary construction is that it is enhanced by the GPs' descriptions and explanations of their complementary therapies. The analysis illustrates how the rhetorics employed to describe general practice (artistic, intuitive, patient-centred and holistic) are also prominent rhetorics in the doctors' descriptions of their complementary medicine. As Dr 25 explains in relation to homeopathy:

Homeopathy...it's looking at the whole person and their past, their present, their relationships, their preferences. You gain that in a primary care setting which you do not, I don't think you gain that at all in a secondary specialist setting.<sup>8</sup>

This feature of the GPs' accounts shows that complementary therapies provide these doctors with a valuable rhetorical tool in relation to their ongoing struggles to define themselves in contrast to hospital medicine. Here we have evidence of another ideological task underlying the GPs' accounts of their integrative practice; the doctors' explanations of their complementary therapy also double as part of an interprofessional strategy to gain an identity and role distinct from the paradigm of hospital medicine. To quote Dr 23:

In general practice when the person comes in you have to treat the whole person anyway, so I don't think acupuncture is any different from that because the patient is a whole person. It's not like being a specialist in hospital where

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<sup>7</sup> Dr 6.

<sup>8</sup> Dr 25.

if you refer to the gastroenterologist they will deal purely with the bowel and nothing else.<sup>9</sup>

Similarly, as with the findings discussed in the previous section of this chapter, this conclusion demonstrates the explanatory power of the theoretical approach adopted in the thesis to examine the GPs' accounts. In particular, SWT provides an analytical focus which is sensitive to interprofessional divisions and hence which helps uncover the interprofessional strategy outlined above.

The SWT conceptualisation of parent worlds consisting of numerous subworlds proves extremely useful in interpreting this section of the GPs' talk; it encourages a new perspective with which to examine the medical profession and with which to position general practitioners therein. In effect, SWT spotlights not only the boundary between the parent worlds of conventional and unconventional medicine, but also the boundaries between the subworlds of different branches of medicine from inside the medical profession. As the analysis reveals the GPs' accounts highlight the particular subworlds of general practice and hospital specialisms.

Whereas Saks' previous work on integration has adopted a monolithic approach to the medical profession (presuming homogeneity of interests and perspectives across all practitioners), the data produced from the present study illuminates some of the rivalries and divisions between different medical specialisms. We can see that such findings contribute much to our understanding of incorporation; direct integrative practice must be interpreted not only in terms of medical practitioner/non-medical practitioner divide but also in terms of internal struggles over the division of medical labour and resources.

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<sup>9</sup> Dr 23.

### 8.3.2 Intraprofessional Strategy

Another set of findings produced from the study also supply evidence that the GPs' talk is directed towards more positive strategy than simply a response to the threat posed by lay therapy. However, these findings do not feed into ongoing struggles between different branches of the medical profession; but, instead, relate more directly to the divisions and rivalries between subgroups *within* the field of general practice itself.

More specifically, the analysis in chapter seven outlines how the GPs seek to defend their clinical autonomy from what they perceive to be the threat of evidence-based medicine by drawing upon their descriptions of complementary therapies. As explained earlier, the GPs draw upon the rhetorics of intuition, artistic practice and medical holism when describing their professional identity and role. Elsewhere within the GPs' accounts we can also identify the use of these three rhetorics to perform another quite separate ideological task. The GPs also employ these rhetorics when describing their complementary therapy and, moreover, when demarcating and distancing themselves from the evidence-based movement and its proponents. As Dr 15 explains:

Evidence based medicine and me are in a pickle. I don't believe in it. I find it incredibly threatening to the way I conduct my business of being a GP because I don't conduct it in that way. I might treat your asthma totally differently from that asthma, the same way as I'd do if I was treating it homeopathically.<sup>10</sup>

To some degree this talk does feed into the GP/Hospital boundary work mentioned in the last section – some GPs portray evidence-based medicine as an approach associated with the hospital paradigm. Nevertheless, such talk more prominently relates to intraprofessional struggles between those general practitioners

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<sup>10</sup> Dr 15.



developing an evidence-based approach within their surgery and the GPs personally integrating complementary medicines within their treatment regimes. In effect, the GPs contrast these two developments and the two sets of practitioners involved.

The identification of this strategy relating to intraprofessional groupings, like the interprofessional strategy discussed earlier, is facilitated by the use of the social world concept of subworlds. Those sections of the GPs' accounts which pertain to the issue of evidence-based medicine reveal the potential of utilising this concept with the interpretation of two, amongst many other, subworlds competing for cultural space and resources within general practice. These competing subworlds are clearly drawn upon by Dr 19 when he suggests:

You see there's the whole other push of evidence based medicine, that doctors should only do things where...the research has proven it works...and acupuncture's the same, you know a lot of people would say right well you're not allowed to give it because it's not evidence based.<sup>11</sup>

This point directs us to another element of SWT (also found within Gieryn's social cartographic perspective) which is useful for interpreting these particular segments of the GPs' talk. Both of these perspectives highlight the essentially *constructionist* nature of professional communities. In other words, they encourage us to conceptualise the territory and terrain of professional communities as neither predetermined nor fixed but, alternatively, as the constant focus of in-world debate and negotiation.

Such a perspective is highly suited to an interpretation of the GPs' talk. It enables us to identify two subworlds within the world of general practice (the one centred on an evidence-based approach and the other grouped around the theme of direct integrative practice) each claiming different (and contrasting) notions of good

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<sup>11</sup> Dr 19.

and authentic general practice. As such, the GPs' accounts provide evidence of how those members belonging to the subworld of direct integrative practice attempt to promote their vision of general practice, while, at the same time, also attempting to demote the vision of those supporting evidence-based general practice. For example Dr 25 draws upon the theme of randomised controlled trials as a means of accomplishing this task:

It's a fact that no matter, your gold standard randomised controlled trial is about thirty patients that get this and thirty that get that and then you generalise the experience of the thirty and you generalise the experience of the other thirty and it's actually about nobody's experience, it's not about one individual's experience. The problem is the idea and philosophy behind randomising people is so alien to what my central opinion is as to what you do when a patient comes to seek help in front of you

Interviewer: So is something missing? Why is evidence based medicine so alien to your idea of practice?

Because you've got the art of individual, it's the individual.<sup>12</sup>

Here we have clear evidence of how one faction of GPs accomplish and manage their ongoing struggles with another general practice subgroup over the definition and organisation of their wider parent world.

Closely linked to this interpretation of subworlds is the social world concept of authenticity. The conflicts between the subworld of direct integrative practice and others within general practice (such as that based upon an evidence-based medicine) ultimately centre upon the authenticity of technologies, practices and members within the wider parent world. We can see from the GPs' accounts that these doctors make numerous claims as to why their style and approach to general practice (including the practice of unconventional therapies) is authentic and why the features of an evidence-based medicine are inappropriate and detrimental to good general practice. For example, the GPs present general practice essentially as involving close social

relationships, treating the whole person and an artistic form of medicine. These features are then contrasted with the reductionist and quantitative approach of EBM which threatens these cornerstones of general medicine.

Authenticity is a concept that is also particularly helpful in understanding other areas of the GPs' accounts. This concept equally relates to the attempts of the GPs in the study to appropriate their unconventional practice in order to convince others within their branch of medicine of the worth of such treatments. The next section outlines those findings produced from the study that relate directly to this appropriation process.

#### **8.4 Appropriating and Authenticating Complementary Therapies**

Another way in which the study adds to our understanding of incorporation is in its illustration of how these GPs attempt to transplant 'exotic' practices into their conventional medical subworld. As illustrated in chapter five, much of the GPs' arguments and claims act as potentially forceful and persuasive devices in the internal debates within general practice about the worth and authenticity of integrative complementary therapy. For example, some GPs suggest unconventional therapies fill many of the treatment gaps left from ineffective conventional medicines. Dr 24 explains:

I thought [acupuncture's] quite interesting because there's a lot of things we're not very good at treating, headaches, back pain, that sort of thing, so that's when I got interested.<sup>13</sup>

Meanwhile, other GPs highlight what they claim are the long-term savings in time and money from introducing unconventional therapies. As Dr 5 explains:

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<sup>12</sup> Dr 25.

<sup>13</sup> Dr 24.

You know, if you take it over a time-scale of ten to fifteen years and count up how often these people are at a surgery if you can deal with it in two sessions of hypnosis you're actually saving time at the end.<sup>14</sup>

Previous study has not concerned itself with the processes whereby GPs appropriate and authenticate their complementary medicine to other doctors less enthusiastic or opposed to such 'alien' practices. This neglect is not surprising, given the focus of Saks' work upon the approach of the medical elite to unconventional therapies. Meanwhile, appropriation and authentication processes accompanying the integration of complementary medicine within general practice are essentially processes undertaken and accomplished at the grass-roots level of the conventional medical world.

This is another area where the theoretical framework developed in the study produces new findings concerning integration. The focus of the study upon world members' accounts of their therapies allows the first in-depth exploration of these appropriation and authentication processes. The analysis of the GPs' accounts reveals some of the ways in which these doctors attempt to accomplish the difficult task of translating practices from one world to another in the competitive arena of health care.

These findings also show another strength of the theoretical framework promoted in the study. Conceptualising social worlds as speech communities (with help from elements of both Bloor's and Plummers' work) enables this interpretation of the GPs' accounts in terms of ongoing struggles between grass roots doctors over the authenticity of practices within this world of medicine. Once again, we can see the contribution this work makes to the study of integration through the refocus away from official rhetorics of the medical profession to the talk of rank-and-file practitioners.

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<sup>14</sup> Dr 5.

## 8.5 Rhetorical Features Across Themes

So far this chapter has discussed a number of empirical findings in terms of their relationship to wider professional strategies: defensive strategy; intraprofessional strategy; interprofessional strategy; and appropriation and authentication. However, this section outlines another set of findings produced from the study which relate more specifically to the rhetorical features of the doctors' accounts and which cut across these different strategies. These rhetorical features relate much more closely to the social psychology and micro-sociology approaches that concentrate their attention upon the very details of talk.<sup>15</sup> The analysis from the present research has revealed two such features - flexibility and contingent/non-contingent repertoires - and these will now be discussed in more detail.

### 8.5.1 The Flexible Employment of Interpretative Frameworks

One principal aspect of the accounts which has been identified in the analysis is flexibility. This refers to the tendency within the GPs' talk to tailor or orientate descriptions and explanations to a range of diverse ideological tasks. To elaborate, examining across and within the GPs' accounts it is possible to distinguish a specific feature: divergent (and often contrasting) interpretative frameworks are repeatedly drawn upon to describe and explain the same one topic of talk.<sup>16</sup>

The analysis provides a number of examples which illustrate this point. As demonstrated in chapter four the rhetorics of risk and danger are drawn upon by the GPs in their attempts to distance themselves from lay therapists. A number of claims

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<sup>15</sup> Potter, J. (1996). *Representing Reality*. London, Sage. Potter, J. and Wetherall, M. (1994). 'Analyzing Discourse'. In Bryman, A. and Burgess, R. (eds). *Analyzing Qualitative Data*. London, Routledge.

are made as to why both alternative style therapies (as distinguished from complementary style therapy practised by the GP) and non-medically qualified therapists pose dangers to patients. Amongst these claims is the suggestion that certain unconventional therapeutic procedures are themselves 'risky' and therefore require the expertise and judgement of a doctor to ensure safe best practice; the GPs explain how their role in practice is to provide protection and assurance to the patient. For example, as Dr 11 explains his use of acupuncture:

I think the safety of it, the safety of being medical and using something like needles, you know, there a few points around where you are dicing with death...so there's the odd thing like that where I think my medical training and knowledge of anatomy and everything else like that is better.<sup>17</sup>

In those passages of talk like the one above, the GPs draw upon these rhetorics of risk and danger to good effect: a clear distinction is carved between lay and medical practice of unconventional medicines, a distinction which, as we have seen earlier in this chapter, is central to the GPs' attempts to not only capture other practices but monopolise them.

However, turning our attention to the appropriation and authentication processes explored in chapter five we discover a contrasting presentation of unconventional therapies. In these cases – where the GPs justify their incorporation of complementary therapies into their general practice – unconventional medicines are described as safe and natural. As Dr 7 states:

You know there are an awful lot of things that we can't do a lot for anyway and you're as well giving a homeopathic preparation which isn't going to harm them than give them other things which don't always help and which have side-effects.<sup>18</sup>

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<sup>16</sup> Flexibility is a feature of talk highlighted and analysed by discursive psychologists. See Wetherall, M. and Potter, J. (1992). *Mapping the Language of Racism*. London, Harvester Wheatsheaf.

<sup>17</sup> Dr 11.

<sup>18</sup> Dr 7.

Here the purpose is to distinguish complementary therapies from those conventional drug-based treatments which pose potential iatrogenic effects. As we can see in these competing descriptions of complementary therapies, the GPs draw upon contrasting rhetorics to accomplish different tasks – while on the one hand they bid to demarcate themselves and their practice from that of non-medically qualified therapists, on the other they seek to appropriate and thereby, more specifically, justify complementary practice within their surgeries.

Another example of the use of divergent interpretative frameworks identified from the analysis of the GPs' accounts relates to descriptions of the identity of general practice. The analysis in chapter four illustrates how the distancing from lay therapy and therapists is partly accomplished through an appeal to the necessary role of conventional scientific medicine. The GPs legitimise their complementary practice in terms of conventional diagnostic procedures, procedures which are deemed *fundamental* to good complementary therapy. To quote Dr 21:

I would like to think that I would, you know, I wouldn't miss serious pathology, that I wouldn't be treating someone with a homeopathic remedy who should be you know having their cancer removed sort of thing...it may be that an unmedically qualified homeopath may miss symptoms which should be properly investigated.<sup>19</sup>

In this way, the doctors stress the rhetoric of science in their descriptions of their clinical practice and identity; science is employed as a powerful rhetoric with which to distinguish general practice from, and elevate it above, the techniques of non-medically qualified therapists. However, again – as with the rhetorics of safety and risk – exploration of other areas of the GPs' talk indicates the application of another contrasting set of rhetorics to describe the role and identity of general practice. When focusing their talk upon the hospital/GP border the doctors contrast their practice with



the scientific approach of hospital medicine by emphasising what they explain as the intuitive and artistic features of GP consultations. As Dr 24 explains:

I'm looking at an individual as a person in an environment surrounded by home and family and community...I think there's a lot more of the art of medicine which can be practised in general practice. It's not to denigrate the hospital practitioners, but they have a totally different constraint in which they have to operate.<sup>20</sup>

Now, it is important that such flexibility within the accounts is not simply glossed over or dismissed as inconsistency on the part of these GPs. As discursive psychology and other variants of discourse analysis have illustrated, drawing upon a whole range of different rhetorics to accomplish different ideological tasks is a normal and necessary feature of all talk. Following features from these perspectives, the present study helps illustrate how the ability of the GPs to draw upon divergent interpretative frameworks when explaining complementary medicine is central to their attempts to maintain and secure medical dominance and 'expert' status within the health care arena. The examination provided by the thesis of how such flexible use of frameworks is managed is central to an understanding of the strategies whereby medical dominance is maintained and professional standing defended in the face of claims from competing health care providers.

### **8.5.2 Contingent and Non-Contingent Repertoires**

Across the different boundary-constructions and professional strategies identified from the GPs' accounts is another prominent and potent rhetorical device which these GPs draw upon to accomplish particular ideological tasks. Modifying concepts from the work of Gilbert and Mulkay it can be seen that the doctors' contrasting descriptions of their own medical practice with that of other practitioner

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<sup>19</sup> Dr 21.

<sup>20</sup> Dr 24.

groups reveals the use of contingent and non-contingent interpretative frameworks.<sup>21</sup>

When describing their own medical practice the doctors draw upon a non-contingent repertoire – a repertoire which portrays the speaker's position as above and beyond self-interest or ideological bias. The GPs in the study explain their practice and that of fellow GPs as patient-centred. For example, some GPs justify their development of unconventional therapies in terms of helping make such treatments available to patients who otherwise would not be able to benefit from other types of medicine. As Dr 22 claims:

I think that a reason I'm doing it is because that I feel a lot of my patients can't afford private acupuncture and they wouldn't get acupuncture any other way. If it's £30 for half an hour a lot of my patients are on income support and they just couldn't do it.<sup>22</sup>

This talk portrays general practice as focused upon the interests of patients and thereby void of professional self-interest. This presentation is particularly effective in the boundary demarcations from both lay therapists and the hospital medicine of specialists. The two sets of practitioners are attacked through the use of contingent repertoires. In contrast to the description of general practice as based upon patient-interests, this contingent repertoire presents both hospital medicine and alternative therapy as governed by professional self-interest. These explanations are formulated in a number of different ways. Both lay therapy and hospital medicine are condemned as narrow and inflexible in their treatment approach. In the case of alternative practice some GPs refer to the free market environment in which most non-medically trained therapists compete directly for custom as diluting any notion of treatment driven by

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<sup>21</sup> Here I refer to Gilbert and Mulkay's study of scientists' discourse which reveals the use of contingent and empiricist repertoires in an effort to present their own theoretical position as factual and that of other scientists as contaminated by social and political influences. For details of these frameworks see Gilbert, N. and Mulkay, M. (1984). *Opening Pandora's Box*. Cambridge, Cambridge University Press.

<sup>22</sup> Dr 22.

altruistic motives; financial considerations are highlighted as predominating over the needs of patients.

In the case of hospital doctors, by contrast, attention is given within the accounts to the detached location of specialist care. Concentrating upon a lack of continuity and an indulgence in academic medicine, hospital consultants are characterised as removed from patient perspectives and experiences and therefore as failing to fully appreciate patient needs. As Dr 14 explains his view of hospital doctors:

...they're there to deal with an illness, they're not there to deal with the patient. They've been trained and that's why I say medical training does close you down a bit. If you're a specialist in cardiology then you're interested in hearts, end of story, the patient becomes somebody that you're interested in because of the disease.<sup>23</sup>

Furthermore, some GPs also explain specialisms as breeding particularly hierarchical and competitive institutional cultures where world members often enter medicine not to create close or meaningful relationships with patients but for the sheer intellectual indulgence this type of medicine allows and the status it also attracts.

Many of the doctors employ descriptions of and justifications for complementary practice along the lines of these broad interpretative frameworks. For example, as one GP explains:

I feel you've got conventional medicine here and this holistic approach to the person, to their body language, to their needs, and just treating the person not just as a knee or a hysterectomy but as a person who has needs and requires support and counselling maybe, sympathy, understanding, a listening ear and then from that you can start including the other things like acupuncture and homeopathy and so on, they fit in very well with the concept.<sup>24</sup>

There is much talk of complementary therapies enhancing a patient-centred approach to practice either through cultivating a more involved consultation style or by

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<sup>23</sup> Dr 14.

<sup>24</sup> Dr 2.

introducing additional treatment options which enable the practitioner to mould treatment to the specific needs of the individual patient. Here we can see how the analysis identifies a rhetorical device common to many of the ideological tasks associated with the accounts. As with the feature of flexibility, the identification of these contingent/non-contingent interpretative frameworks is a valuable insight into how the GPs establish and maintain their dominance over other health care practitioners in the medical arena.

## **8.6 Weaknesses of Theoretical Perspectives in Interpreting the GPs' Accounts**

Until now, this chapter has highlighted the role of particular elements of the theoretical framework in helping to explain the GPs' accounts of their complementary therapies. Indeed, the new theoretical approach, drawing upon a number of different traditions and consisting of a combination of elements from these perspectives, contributes much to our understanding of the substantive topic of direct integrative practice.

However, the analysis of the GPs' accounts also reveals certain weaknesses associated with some of these perspectives. This point provides further justification for the particular framework developed in the study. Indeed, the very need to combine elements from different theoretical approaches is due to shortcomings of original perspectives in understanding the data. The study developed a critical awareness of these perspectives and this chapter now sets out critically to appraise the different approaches drawn upon in the study as identified from the analysis of the data.

First, the data produced from the study illustrates some of the shortcomings of traditional discursive psychology and other micro-analyses of talk. Such perspectives have been influential and important in directing elements of the analysis undertaken in

the thesis. However, analysis of the GPs' accounts reveals the relationship between the GPs' talk and the wider political context of the health care arena. For example, as identified in previous sections of this chapter, many of the GPs attempt to develop an identity for general practice which is separate to the hospital paradigm and in other areas of their accounts they attempt to discredit lay therapy and monopolise the ownership of unconventional medicines. Discursive psychology and similar micro-approaches fail to contextualise accounts in this way (they fail to delocalise talk) and this point exposes a major weakness of such perspectives in interpreting the GPs' talk collected in the research. The data shows that when dealing with a substantive topic such as direct integrative practice it is essential to consider and incorporate the wider political context when analysing informants' accounts. To deny this point is effectively to underplay the point that complementary therapies, like all forms of medicine, are intrinsically highly political and cultural practices. As we have seen already in this chapter, in response to this shortcoming the research introduces the wider structural framework of SWT<sup>25</sup> alongside discursive approaches enabling the GPs' accounts to be understood in terms of wider group politics and dynamics.

Yet this supportive role for SWT also underlines a major shortcoming of a traditional social world perspective in explaining the GPs' talk. Traditionally, SWT fails to adequately acknowledge the role of language in sustaining social worlds. Indeed, while conceptualising of social worlds as universes of discourse, social world researchers have, nevertheless, not seen members' accounts as a viable research tool for investigating worlds.

However, the findings from the present study illustrate how we can operationalise the concept of social worlds as self-referential speech communities

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<sup>25</sup> Strauss, A. (1978). 'A Social World Perspective'. *Studies in Symbolic Interaction* 1: 199-228.

when researching substantive topics such as direct integrative practice. The thesis shows how the GPs' talk can be interpreted as the ongoing accomplishment of wider social world processes. In this sense, the study highlights how it is necessary to examine world members' presentations in order to identify and understand the very methods whereby a world is maintained. Such a need emphasises the essential role micro sociological approaches play within a wider social world framework.

The findings from the present study also reveal another shortcoming of SWT (as presented by previous writers) when making sense of the GPs' accounts. As we have seen earlier in this chapter, alongside the doctors' GP/lay therapy demarcation are attempts also to distance these two styles of practice and practitioner. As Dr 9 illustrates when she says:

I retain an open mind but the lay therapists, I think, I believe practise homeopathy slightly differently, differently to the way we've been taught. I don't want to comment too far on that, I just feel that to keep it in context it should be people with a medical background...because that's where we're using it, we are using it in the medical context.<sup>26</sup>

This means the GPs in the study are appropriating practices from the unconventional medical world yet are not appropriating practitioners from this other world; the GPs firmly locate lay therapists outside the boundaries of general practice.

Now, these findings constitute a problem for traditional SWT. Social world researchers have invariably used a social world framework to investigate case studies where worlds co-operate and collaborate in order to develop new worlds.<sup>27</sup> As a result, a traditional social world approach can offer no specific concepts for interpreting the features of appropriation identified from the GPs' accounts. In response to this point, the thesis modifies a social world framework to offer a new

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<sup>26</sup> Dr 9.

<sup>27</sup> For example, see Clarke, A. (1990). 'A Social World Research Adventure'. In S. Cozzens and T. Geiryn (eds). *Theories of Science in Society*. Bloomington, Indiana University Press.

concept – weak intersection – to help interpret those circumstances, like in the present case study, where practices and technologies are transported from one world to another yet the members of each world continue to compete in separate sites of practice rather than collaborate in multidisciplinary settings.

### **8.7 Some Limitations of the Study and Proposals for Future Research**

As this thesis has shown the topic of direct integrative practice provides us with an opportunity to investigate how one medical group manages and constructs medical boundaries, identities, roles and territories. While the present study helps understand core elements of these issues, there is also much potential for further research to explore other aspects of this topical and interesting area of the medical world. These possibilities for future research can be explained in relation to the limitations of the thesis.

A major limitation of the present research centres around the focus of the theoretical framework developed for the study. While reorientating a social world perspective to incorporate a more detailed examination of one world members' accounts, the study moves away from the broad scope of analysis traditionally associated with the social world approach of such writers as Clarke and others.<sup>28</sup>

One advantage of the traditional social world perspective in examining case studies is its ability to analyse a multitude of different worlds and their involvement in a particular arena. Keeping this social world feature in mind, it is acknowledged that the present study restricts its focus entirely to one particular subworld involved in unconventional practice. The study only investigates general practitioners and, furthermore, only those practitioners who personally practise unconventional



therapies in their surgery. As a result, the study neglects to subject other worlds in this arena, and their respective members' claims and arguments, to in-depth examination.

There are a number of specific groups which play a significant part in the competing arena surrounding unconventional practice. Outlining each highlights areas for further study which complement the present research and might add to our understanding of the role and location of unconventional therapies in relation to conventional medicine in contemporary society.

First, we must remember that the GPs in the study are all personally practising complementary therapies. There are also doctors supporting the integration of unconventional medicines within general practice in other ways (e.g. organising referrals or encouraging patients to self-refer) and others who simply support the medicines in principle yet have no involvement with the therapies either directly or indirectly. In terms of SWT we can conceptualise these additional GPs as possibly fringe members or temporary tourists within the subworld of direct integrative practice. Such GPs undoubtedly play an important role in transmitting unconventional practices and technologies within the general practice community and their descriptions and explanations of unconventional medicines are also valuable to understanding the in-world struggles orientated around unconventional therapies and their future location and role within general practice. One task for future research would be to explore how these GPs justify their support and/or interest in complementary medicines and the relationship between the accounts of such GPs and those of core subworld members examined in the present study.

Staying momentarily within the boundaries of general practice, the presentations of another group of GPs contributes to the intraprofessional debates

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<sup>28</sup> Clarke, A. (1991). 'Social Worlds/Arenas Theory as Organisational Theory'. In D. Maines (ed.). *Social Organisation and Social Process: Essays in Honour of Anselm Strauss*. New York, Aldine de

surrounding unconventional medicines. A potentially fruitful line of investigation for future study is an examination of the talk of GPs who actively oppose the integration of unconventional therapies within general practice. This subgroup of GPs are the particular focus of the GPs' appropriation and authentication of complementary therapies as outlined in chapter five; they represent the hard case against which the claims and arguments that complementary therapies are suitable for general practice can be tested.

Turning attention away from the internal groupings within general practice towards the more general border between medical practitioners and lay therapists also helps detect areas for future research. Effectively, the present study examines just one side of this boundary demarcation, that of general practice, though what is needed is also a detailed investigation into the world of lay therapy, its subworlds and world members' accounts. Future research can help understand how lay therapists describe their identity and territory, how they present their relationship to the medical profession and, moreover, how these explanations relate and compare to the GPs' accounts examined in this thesis.

A common theme running through the proposals for future research outlined above is that they all contribute to an analysis of how numerous different groups of practitioners construct and manage the terrain of health care provision. However, we should not restrict our scope of analysis to just health care providers; health care users also play an important role within the health care arena. Future research is needed to examine patients' experiences of direct integrative practice and the interface between practitioner and patient understandings of complementary therapies. As such, there is a need for detailed study of the doctor- patient consultation regarding integrative

practice in order to understand the integration of complementary therapies as an ongoing accomplishment on the part of both practitioners and patients.

Furthermore, as this present study suggests, the integration of complementary therapies within general practice does not simply involve doctor-patient interactions. Equally as important are practitioner-practitioner relations. As a result, an interesting focus for future research is the day-to-day interaction between doctors and other professional colleagues within general practice as they debate and negotiate the legitimacy and authenticity of complementary therapies therein.

As the last two proposals for future research illustrate, there is a need to complement the present study by employing different research methods to investigate direct integrative practice. While ethnographic methods have not been used in this research,<sup>29</sup> I would, however, argue that they constitute one possible methodology which holds great potential for exploring the substantive topic of incorporation and also for enhancing the conceptualisation of medical worlds and associated analytical concepts employed in the present study.

Other limitations of the thesis relate to the specific methodological approach and methods employed in the study. In hindsight, while faced with the problem of identifying and making contact with GPs practising unconventional therapies, the preliminary questionnaire survey was not necessary. The data collected by this postal survey (apart from the response to the request to be interviewed) was not analysed and, instead, a letter requesting participation in interviews may well have been sufficient to enrol the number of doctors needed for the later stages of the fieldwork. Turning to the analysis of the GPs' accounts, it would also have certainly been beneficial to work with other researchers throughout the coding and analysis of the

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<sup>29</sup> See chapter three for discussion of this point.

data collected. However, such an approach was restricted by the financial and time constraints of the PhD process.

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## **Appendix 1.**

**QUESTIONNAIRE: A STUDY OF COMPLEMENTARY THERAPIES WITHIN GENERAL PRACTICE**

**A) PRACTICE DETAILS**

*1. How many years have you been in general practice?*

- 1 – 5 years ☐
- 6 – 10 years ☐
- 11 – 20 years ☐
- More than 20 years ☐

**B) REFERRALS**

*2. Do you undertake any of the following?*

	Yes	No
Refer patients for complementary therapies	<input type="checkbox"/>	<input type="checkbox"/>
Encourage self-referral of patients for Complementary therapies	<input type="checkbox"/>	<input type="checkbox"/>
Refer patients to others in your practice with an interest in complementary therapies	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered YES to any part of Q2 please go to Q3 below  
If not please go directly to Q7

*3. When did you first begin to refer patients for complementary therapies?*

- Less than 12 months ago ☐
- 1 – 2 years ago ☐
- 3 – 5 years ago ☐
- 6 – 10 years ago ☐
- More than 10 years ago ☐

**4. For which therapies do you refer?**  
*(Tick as many boxes as relevant)*

- Acupuncture ☐
- Aromatherapy ☐
- Chiropractic ☐
- Homeopathy ☐
- Medical Herbalism ☐
- Osteopathy ☐
- Reflexology ☐
- Other(s) (please specify)  
.....

**5. What type of complementary practitioner do you refer to?**

- Only to medically qualified therapists ☐
- To both medically qualified and non-medically qualified therapists ☐
- Only to non-medically qualified therapists ☐

**6. How did you initially become aware of these therapists for referral?**

- Through medical colleague(s) ☐
- Through courses/lectures ☐
- Through patient(s) ☐
- Through personal experience of Treatments ☐
- Through relatives and/or friends ☐
- Other(s)  
(please specify) .....



### C) PERSONAL PRACTISE OF COMPLEMENTARY THERAPIES

7. *Do you personally practise any complementary therapy(ies)?*

**Yes** ☐ **No** ☐

**If YES please go to Q8**

**If NO please go to Q10**

8. Which complementary therapy(ies) do you personally practise?

*(Tick as many boxes as relevant)*

**Acupuncture** ☐

**Aromatherapy** ☐

Chiropractic ☐

**Homeopathy** ☐

## Medical Herbalism ☐

**Osteopathy** ☐

Reflexology ☐

**Other(s) (please specify)**

.....

9. *When did you first begin offering complementary therapies to your patients?*

**Within the last 12 months** ☐

**Last 1 – 2 years** ☐

**Last 3 – 5 years** ☐

**Last 6 – 10 years** ☐

**More than 10 years ago** ☐

## D) RELATIONSHIP WITH OTHER GPS

**10. Are you aware of any other GPs in Edinburgh/Glasgow who practise complementary therapies?**

**Yes** ☐ **No** ☐

**If YES go to Q11**

**If NO go directly to Q14**

**11. Which therapy(ies) do they practise?**

(Tick as many boxes as relevant)

**Acupuncture** ☐

**Aromatherapy** ☐

Chiropractic ☐

**Homeopathy** ☐

Medical Herbalism ☐

**Osteopathy** ☐

Reflexology ☐

**Other(s) (please specify)**

.....

**12. Do you refer patients to these GPs for complementary treatment?**

**Yes** ☐ **No** ☐

**13. Do these GPs refer patients to you for complementary treatments?**

**Yes** ☐

No ☐

**Not Applicable** ☐

*14. Please outline below any important issue(s) relating to complementary therapies within general practice*

.....  
.....  
.....

*15. If you are available for interview at a later date please provide your name, address and contact number*

*NAME:* .....

*ADDRESS:* .....  
.....  
.....

*CONTACT NUMBER:* .....